JOURNAL

of the

AMERICAN PODIATRY ASSOCIATION

The Official Publication of the Podiatry-Chiropody Profession

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VOLUME 50, NUMBER 9

SEPTEMBER, 1960

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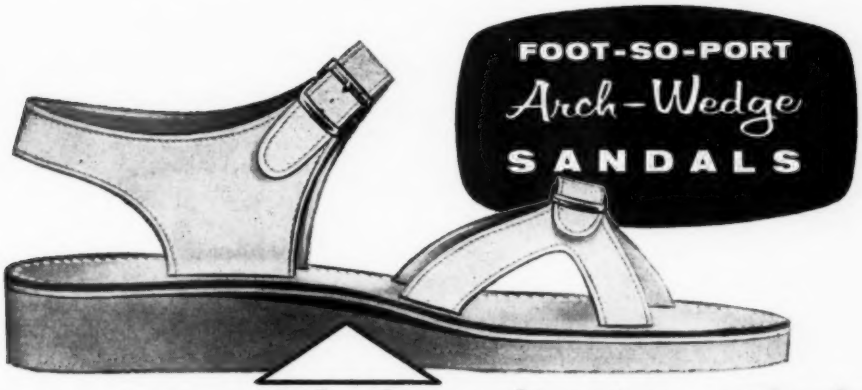

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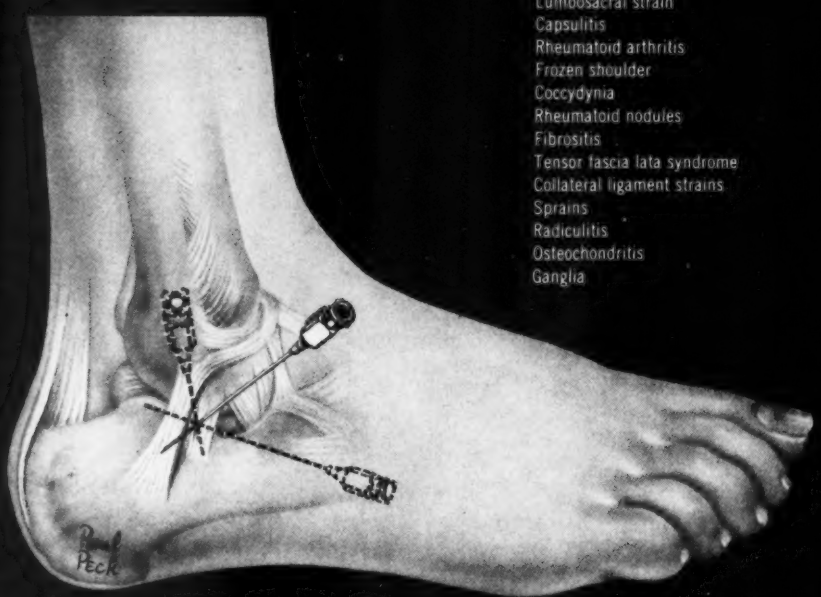

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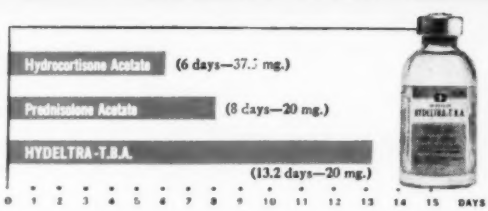
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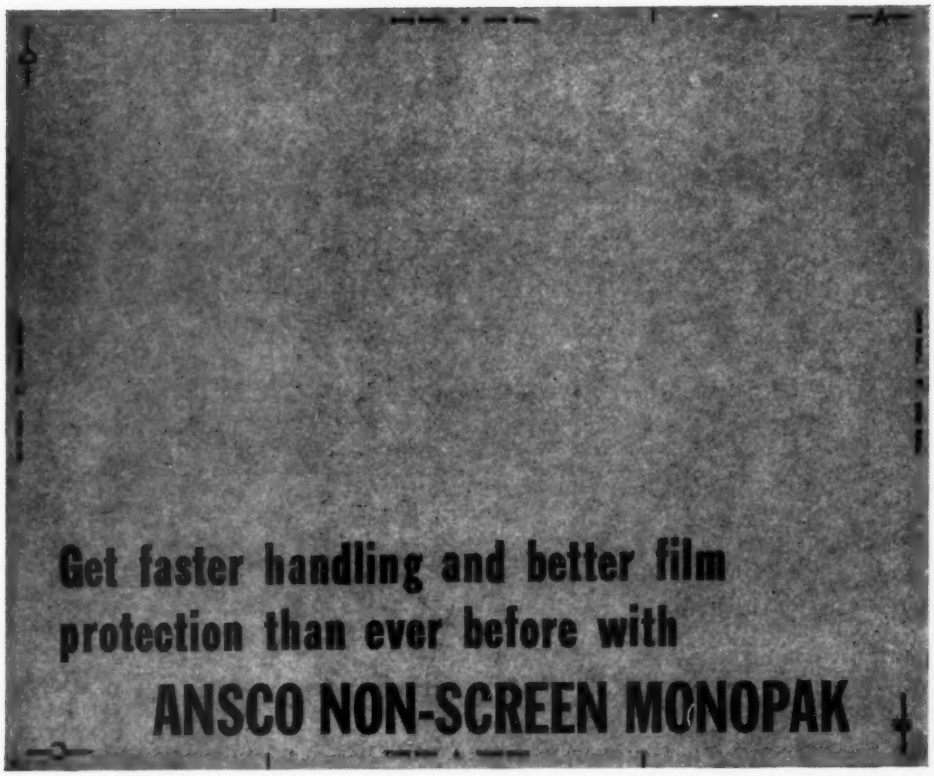

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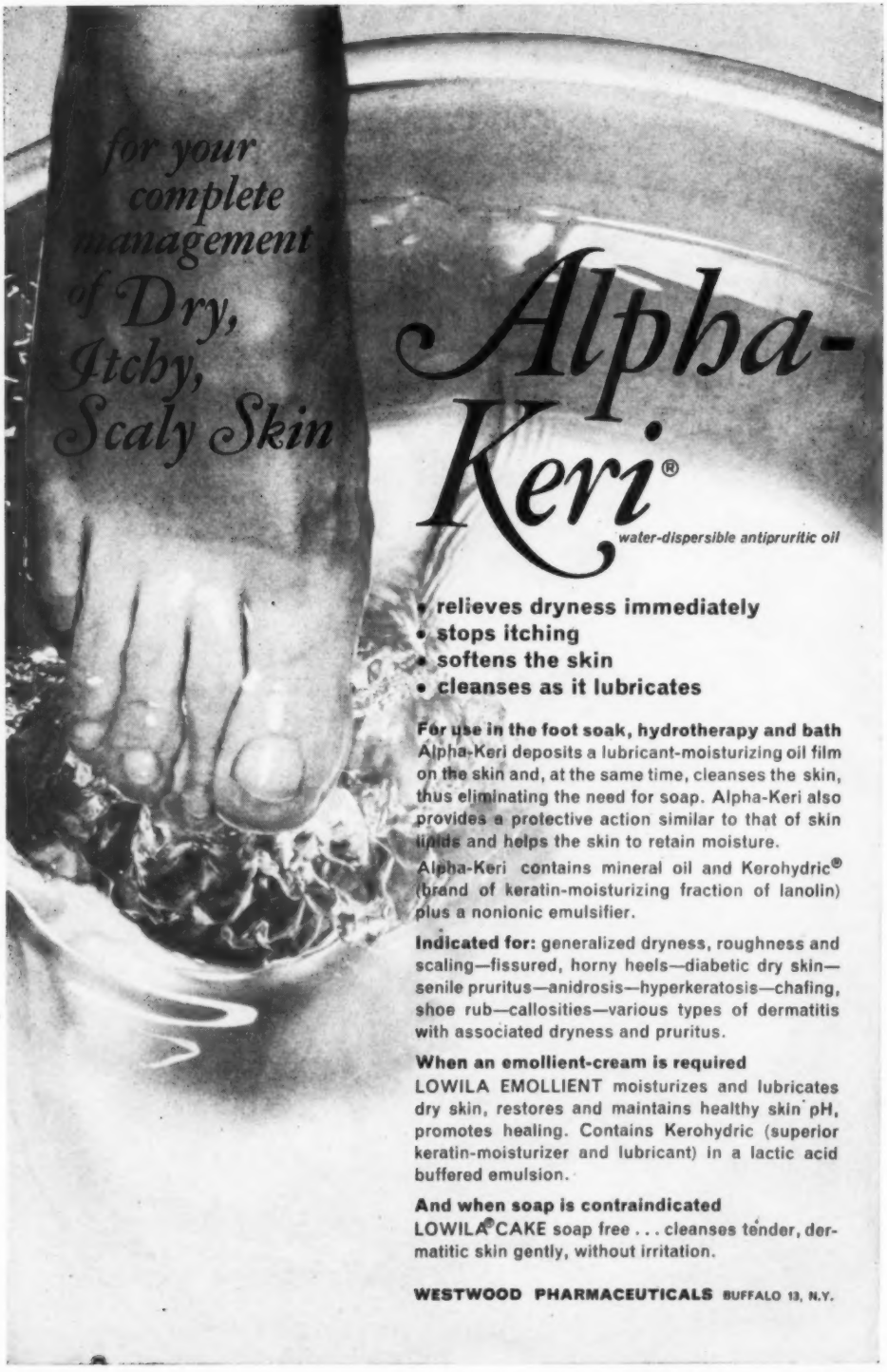
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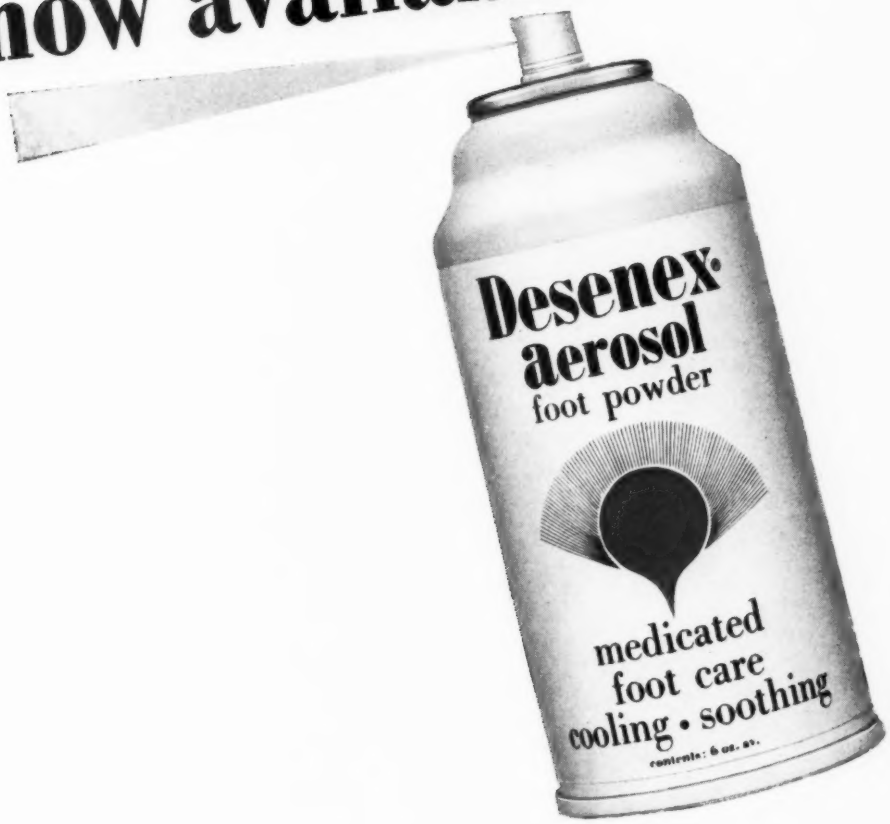

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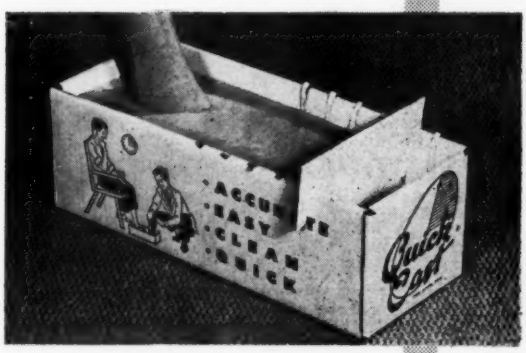

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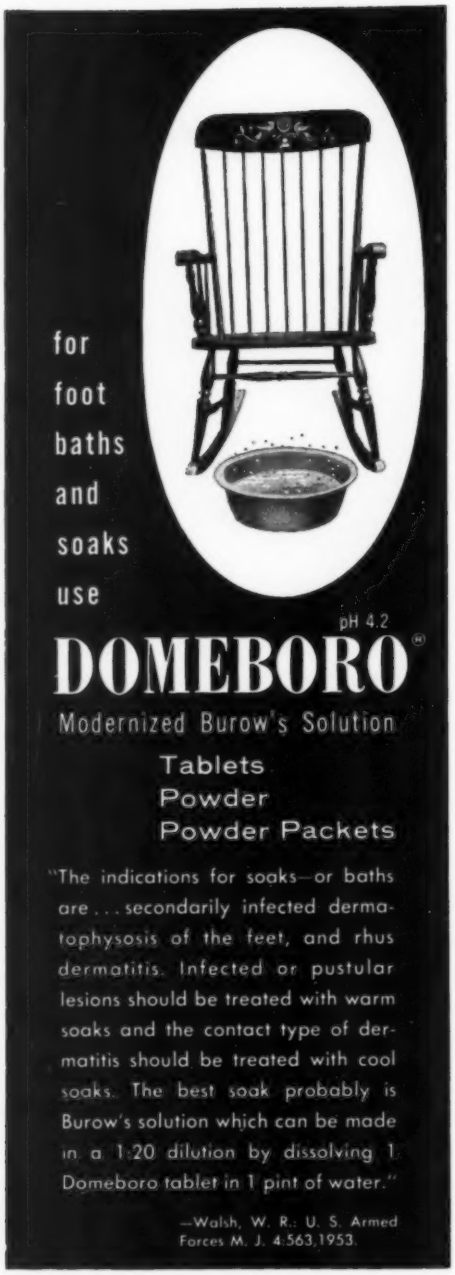
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STATE BOARD MEETINGS FOR EXAMINATION AND LICENSURE

Alabama

The Alabama Medical Board of Examiners. **Board Secretary:**

Arizona

The Arizona State Board of Chiropody Examiners will meet for examination, Oct. 8-9, 1960, at 40 E. Thomas Rd., Phoenix, Ariz. **Board Secretary:** Dr. Julius Citron, 40 E. Thomas Rd., Phoenix, Ariz.

Arkansas

Arkansas State Chiropody Examining Board. **Board Secretary:** Dr. Bernard S. Paul, 1508 Rogers Ave., Fort Smith, Ark.

California

The California Chiropody Examination Committee will meet for examination tentatively in Sacramento, Oct. 17-20, 1960. **Board Chairman:** Abraham Hoffman, D.S.C., 2320 Sutter St., San Francisco, Calif. **Executive Secretary:** Mr. Wallace Thompson, 1021 O St., Sacramento, Calif.

Colorado

Colorado State Board of Chiropody Examiners. **Board President:** Dr. G. F. Helbig, 327 Logan St., Denver, Colo.

Connecticut

The Connecticut Board of Examiners in Chiropody. **Board Secretary:** Dr. F. J. Ruggiero, 3 South Main Street, W. Hartford 7, Conn.

Delaware

The State Board of Chiropody Examiners of Delaware. **Board Secretary:** Dr. Bertram H. Blum, 112 So. State St., Dela.

District of Columbia

The Board of Podiatry Examiners of the District of Columbia will meet for examination semi-annually in January and July. **Board Secretary:** Harry L. Hoffman, Ph.G., D.S.C., Dept. of Occupations and Professions, 1740 Massachusetts Ave., N.W., Washington 6, D. C.

Florida

The Florida State Board of Chiropody Examiners. **Board Secretary:** Dr. Heywood A. Dowling, 203 Greenleaf Bldg., Jacksonville, Fla.

Georgia

The Georgia State Board of Podiatry Examiners. **Board President:** Dr. Charles W. Beasley, Jr., 1205 First National Bank Bldg., Atlanta, Ga.

Idaho

The Idaho State Board of Chiropody-Podiatry. **Board Secretary:** Dr. J. E. Franden, 412 Eastman Bldg., Boise, Idaho.

Illinois

The Illinois Chiropody Examining Committee. **Superintendent of Registration:** Frederic B. Seicke, Room 109, State House, Springfield, Ill.

Indiana

The Indiana State Board of Podiatry Examiners. **Board Secretary:** P. T. Lamey, M.D., 422 Citizens Bank Bldg., Anderson, Ind.

Iowa

The Iowa State Board of Chiropody Examiners. **Board Secretary:** Dr. C. C. Reinheimer, 111 W. 2nd St. South, Newton, Iowa.

Kansas

The Kansas State Board of Podiatry Examiners. **Board President:** Dr. L. E. Krause, 1107 Williams St., Great Bend, Kansas, or Kansas Board of Podiatry Examiners, 872 New Brotherhood Bldg., Kansas City, Kansas. **Board Secretary:** F. N. Nash, M.D., 864 New Brotherhood Bldg., Kansas City, Kansas.

Kentucky

The Kentucky State Board of Chiropody meets on the third Saturday and Sunday of June and the first Saturday and Sunday of December each year. The December meeting is for re-examination only. **Board Secretary:** Dr. Chester A. Nava, 4140 Shelbyville Rd., Louisville, Ky.

Louisiana

Louisiana State Board of Medical Examiners. **Board Secretary:** Edwin Lawson, M.D., 930 Hibernia Bank Bldg., New Orleans 12, La.

Maine

The Maine Board of Examiners in Chiropody and Podiatry. **Board Secretary:** Daniel A. Hanley, M.D., Box 637, Brunswick, Me.

Maryland

The Maryland Board of Chiropody Examiners. **Board Secretary:** Dr. S. Jack Kleger, 408 S. Division St., Salisbury, Md.

Massachusetts

The next board meeting of the Board of Registration in Chiropody-Podiatry will be held for reciprocity, conditionally, and examination, June and December, at Room 33, State House, Boston, Mass. **Board Secretary:** Robert M. Quinn, D.S.C., 16 South St., Pittsfield, Mass.

Michigan

The Michigan State Board of Registration in Chiropody will meet for examination in June of each year. **Board Secretary:** Dr. Albert G. Kalin, 24453 Grand River Ave., Detroit 19, Mich.

Minnesota

The Minnesota Board of Chiropody Examiners. **Board Secretary:** Dr. Palmer H. Goulson, 612 Southdale Medical Bldg., Minneapolis 10, Minn.

Mississippi

The Mississippi State Board of Health. **Board Secretary:** Archie L. Gray, M.D., Box 1700, Jackson, Miss.

Missouri

The Missouri State Board of Chiropody will meet for reciprocity October 7, 1960, at Jefferson Hotel, St. Louis, Mo. **Board Secretary:** Dr. L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.

Montana

The Montana State Board of Chiropody-Medical Examiners will meet when the need arises for reciprocity or examination at the Capitol Bldg., Helena, Mont. **Board Secretary:** Dr. L. M. Jennings, 411 First National Bank, Bozeman, Mont.

Nebraska

The Nebraska State Board of Examiners in Chiropody. **Board Secretary:** Herman F. Gartner, D.S.C., First Natl. Bank Bldg., Lincoln, Nebr.

Nevada

The Nevada State Chiropody Board. **Board Secretary:** Dr. William A. Edwards, 150 No. Arlington St., Reno, Nevada.

New Hampshire

The New Hampshire Board of Registration in Chiropody. **Board Secretary:** Edward W. Colby, M.D., 61 S. Spring St., Concord, N. H.

New Jersey

The New Jersey State Board of Medical Examiners meets semi-annually for examination on the third Tuesday, Wednesday, Thursday and Friday of June and October. **Board Secretary:** Royal A. Schaaf, M.D., 28 West State St., Trenton 8, N. J.

New Mexico

The New Mexico State Board of Podiatry will meet for examination July 15-16, 1961. **Board Secretary:** Morris Haas, D.S.C., 121 Sycamore St., N.E., Albuquerque, N. M.

New York

The New York State Board of Podiatry Examiners. **Board Secretary:** James O. Hoyle, Ed.D., 23 S. Pearl St., Albany, New York.

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STATE BOARD *(Cont.)*

North Carolina

The North Carolina State Board of Chiropody Examiners. **Board Secretary:** Robert W. Getchell, D.S.C., P.O. Box 796, Goldsboro, N. C.

North Dakota

The next board meeting of the North Dakota Board of Registration in Chiropody will be held for reciprocity and examination at call at 301 Black Bldg., Fargo, N. Dak. **Board Secretary:** Joseph E. O'Brien, D.S.C., P.O. Box 872, Bismarck, No. Dak.

Ohio

The Ohio State Medical Board. **Examiner in Chiropody:** H. M. Platter, M.D., 21 W. Broad St., Columbus, Ohio.

Oklahoma

The Oklahoma State Board of Chiropody will meet for examination when necessary, in June and September and other times as needed. **Board Secretary:** Dr. Warren D. Long, 1217 No. Walker St., Oklahoma City, Okla.

Oregon

Oregon State Chiropodists' Examining Board. **Board Secretary:** Richard H. Wilcox, M.D., 914 State Office Bldg., Portland, Ore.

Pennsylvania

Pennsylvania State Board of Chiropody Examiners. **Board Chairman:** Dr. Ralph H. Orr, 424 Colorado Drive, Erie, Pa. **Board Secretary:** Dr. Jack S. Pincus, Box 911, Harrisburg, Pa.

Rhode Island

The Rhode Island Board of Examiners in Chiropody. **Administrator:** Thomas B. Casey, 366 State Office Bldg., Providence, R. I.

South Carolina

The South Carolina Board of Chiropody Examiners will meet for reciprocity and examination at the discretion of the Board. **Board Secretary:** Dr. James D. Hill, 122 W. Whitner St., Anderson, S. C.

South Dakota

The South Dakota State Board of Chiropody Examiners will meet at the discretion of the Board. **Board Secretary:** Dr. Fred D. Rule, 204 Kresge Bldg., Sioux Falls, S. D.

Tennessee

The Tennessee Board of Registration in Chiropody. **Board Secretary:** Stephen A. Lamm, 3355 Poplar Ave., Memphis, Tenn.

Texas

The Texas State Board of Chiropody Examiners. **Board Secretary:** Dr. Lewis M. Hoppock, P. O. Box 3315, Temple, Texas.

Utah

The Utah State Board of Chiropody Examiners. **Board Secretary:** Ward A. Burbidge, 1015 Medical Arts Bldg., Salt Lake City, Utah.

Vermont

Vermont Chiropody Association. **Board Secretary:** Gray S. Clark, Service Bldg., Rutland, Vt.

Virginia

Virginia Board of Medical Examiners. **Board Secretary:** Kenneth D. Graves, M.D., 631 First St., S.W., Roanoke, Va.

Washington

The Washington State Chiropody Examining Committee usually holds Basic Science and Chiropody examinations the first and/or second week in January and July at the University of Washington, Seattle, Wash. **Board Secretary:** Thomas A. Carter, Administrator, Department of Licenses, Olympia, Wash.

West Virginia

Medical Licensing Board of West Virginia. **Board Secretary:** N. H. Dyer, M.D., 1800 E. Washington St., Charleston, W. Va.

Wisconsin

The Wisconsin State Board of Examiners. **Board Secretary:** Roy M. Cowen, 2018 E. North Ave., Milwaukee 2, Wis.

Wyoming

The Wyoming State Board of Registration in Chiropody-Podiatry. **Board Secretary:** Dr. J. W. Scott, 21 East Works St., Sheridan, Wyo.

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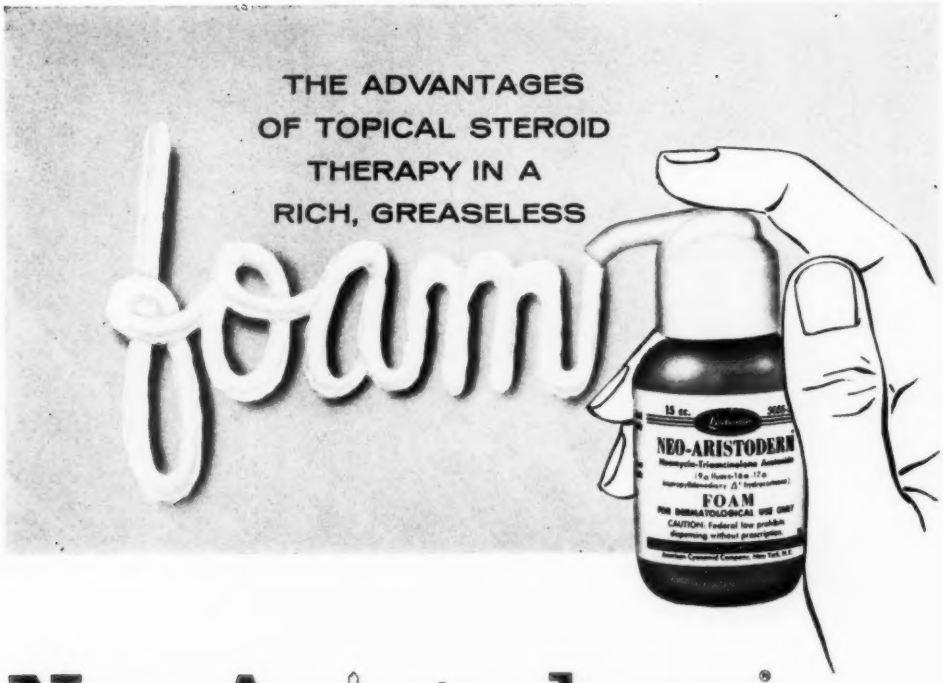

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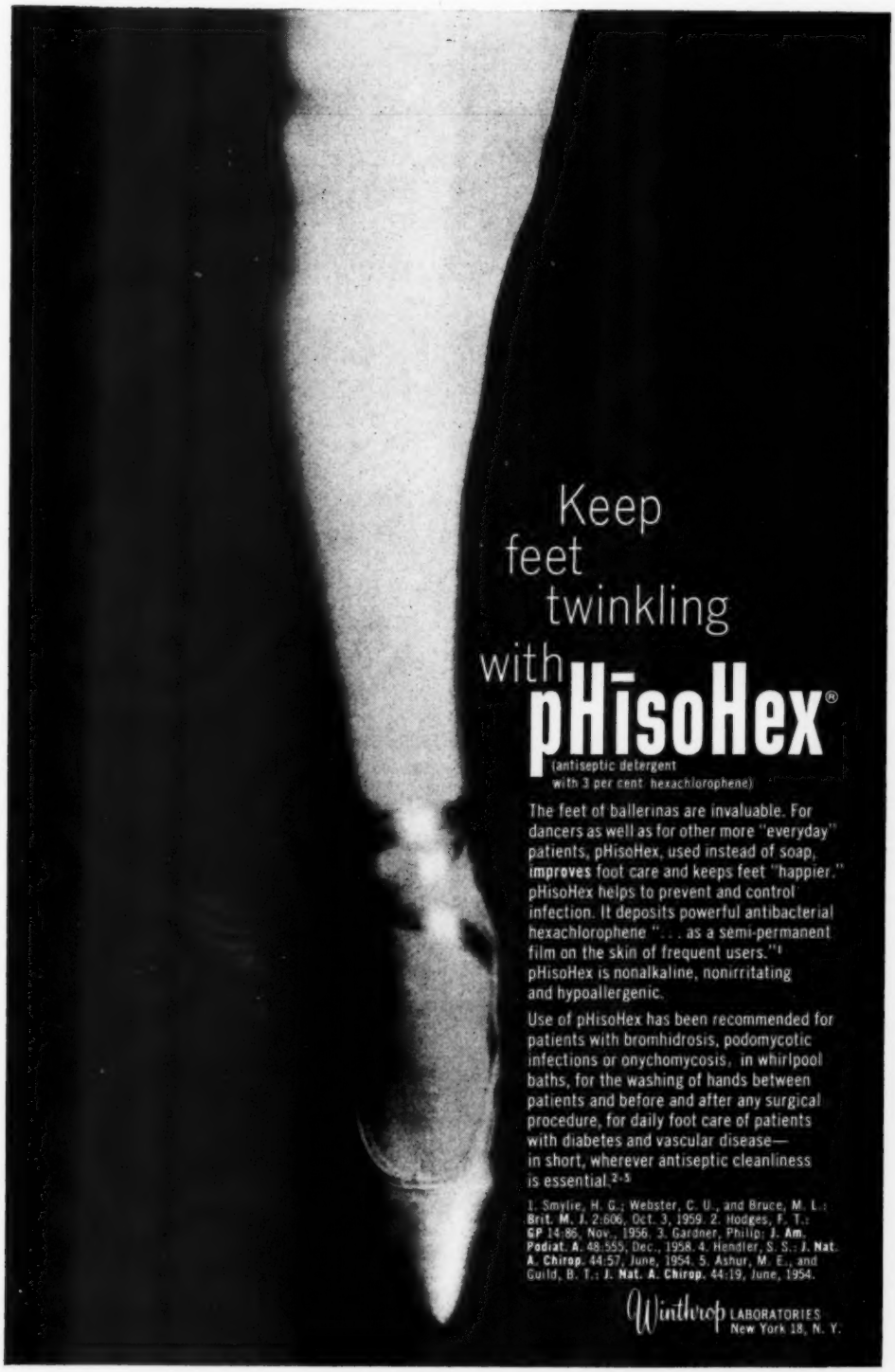
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1. Smylie, H. G.; Webster, C. U., and Bruce, M. L.: Brit. M. J. 2:606, Oct. 3, 1959. 2. Hodges, F. T.: GP 14:86, Nov., 1956. 3. Gardner, Philip: J. Am. Podiat. A. 48:555, Dec., 1958. 4. Hendler, S. S.: J. Nat. A. Chirop. 44:57, June, 1954. 5. Ashur, M. E., and Guild, B. T.: J. Nat. A. Chirop. 44:19, June, 1954.
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William R. Felts, Jr., M.D., Assistant Professor in Medicine, George Washington University Hospital; Associate in Medicine, D. C. General Hospital

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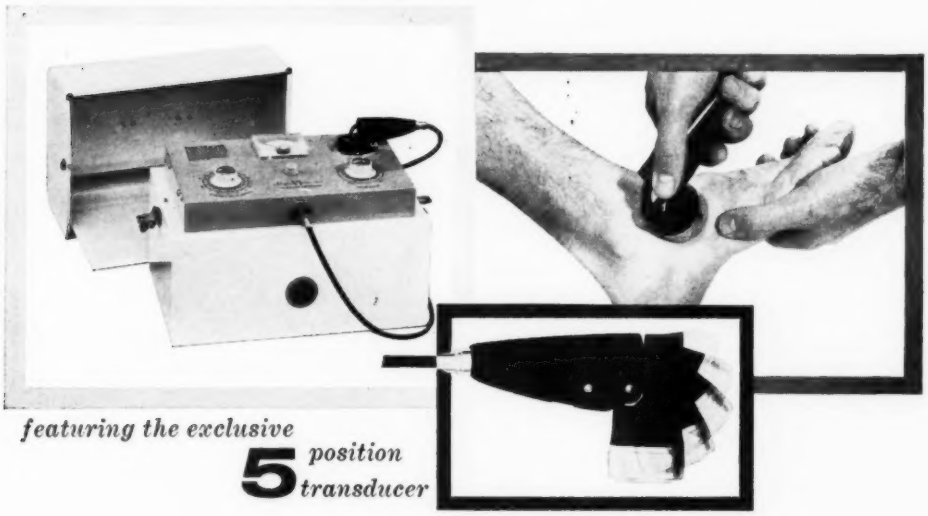

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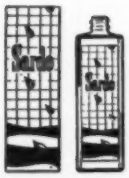

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1. Prentice, H., and Bresak, S.: Jrnl. Amer. Podiatry Assn., May 1958. 2. Spoor, H. J.: N. Y. State J. Med., Oct. 15, 1958.

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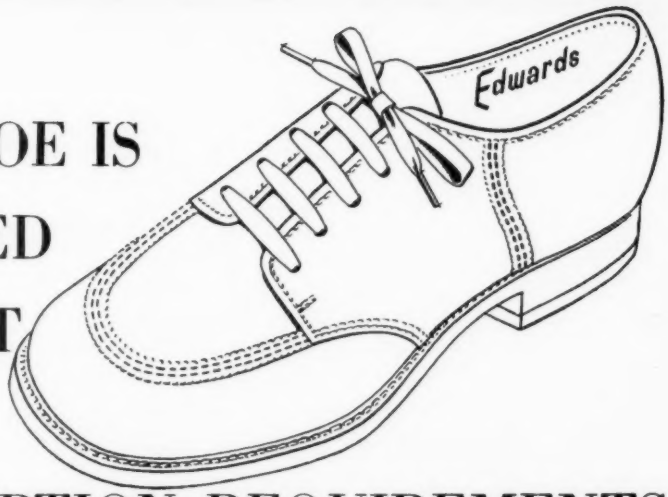

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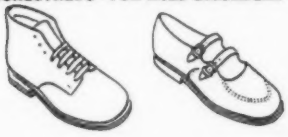

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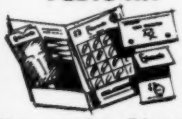

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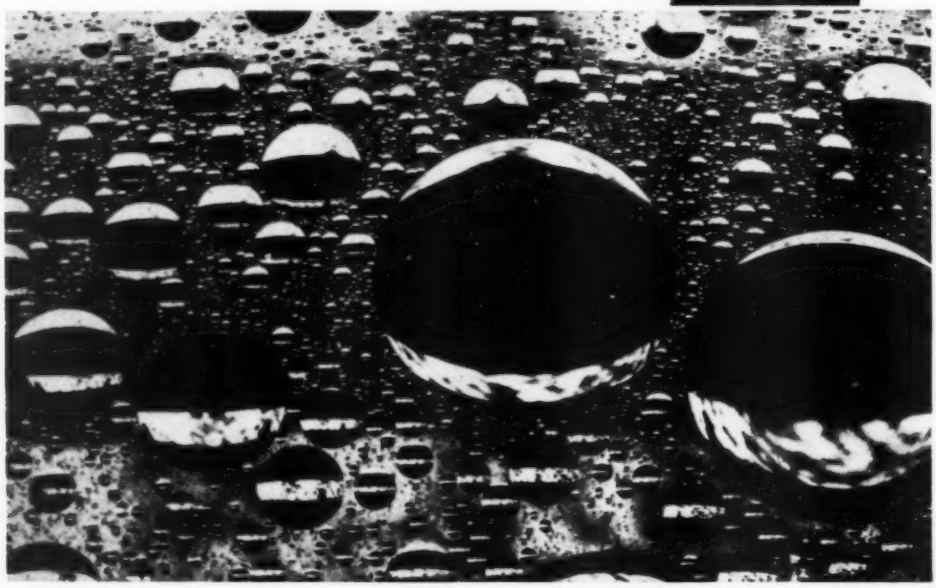

JOURNAL

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THE OFFICIAL PUBLICATION OF THE PODIATRY-CHIROPODY PROFESSION

VOLUME 50 SEPTEMBER, 1960 NUMBER 9

FOOT OF THE FEMALE AS A FACTOR IN MARITAL HAPPINESS

RAYFIELD ARONOW, Pod.D.
Los Angeles, Calif.

AT FIRST glance, the title undoubtedly appears highly presumptuous. Oddly enough, even the foot specialist, so engrossed with upgrading the incorrectly subordinated role accorded the feet by the public and healing professions alike, might also raise an eyebrow—despite the importance the foot represents to him. Yet the relationship exists, remaining only to be recognized, developed and clarified. Along such lines, this paper concerns itself with some preliminary explorations.

By inference, if nothing else, the concept is by no means new. Selecting the turn of the century as the arbitrary demarcation for the rise of modern medicine, it has long recognized the body as an integrated, interrelated unit. (As Feldenkrais[1] points out, there is really no separation of mind and body except for convenience of consideration.) More recently, in this last decade, Wikler[2] treats extensively of the relationship of foot to psychosomatic health from an essentially clinical viewpoint. Even from the broader, more widely known and accepted world of ideas relating to the body-image and self-concept, though, as expounded by people as Schilder[3], Feldenkrais, Mason[4] and those to whom they in turn refer, similar deductions are justifiable. And this is the basis of the present excursions.

That body-image and personality are but the warp and woof of a total pattern is amply demonstrated by Schilder. "There is no body-image without personality," he states. "But the full development of the personality . . . is only possible through the medium of the body and the body-image." This body-image then, is built up from sensory components plus the emotional attitudes derived from experience. It is differentiated, moreover, from the postural model of the body which is essentially physical in nature, being "developed by contact with the outside world." At the risk of criminal over-simplification (considering the books written on the subject), it may be stated that the body-image is the whole person made up of body and mind under the influence of heredity and environment, whereas the postural body model is but the physical appreciation of self, particularly of one's surface and mass in position in space. It is in the formation and re-formation of the body-image and postural body (for by their very nature they are dynamic), that their characteristics and influences are manifested. As in the case of the psyche and soma, however, there is no real differentiation between the two, no point at which one begins and the other leaves off; they are inextricably intertwined, separated only for purposes of convenience.

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The postural model of the body is but one part of the total body-image, the tree trunk from which the limbs and leaves grow.

A baby may be considered a very primitive postural model, a bagful of protoplasm. Its first differentiations are mouth and anus. As it grows, other parts are gradually added to its ken. With the increase in knowledge and understanding, its idea of self becomes additionally endowed with outside influences. It learns it is a boy or girl, and soon begins to respond to the difference in treatment accorded its sex, especially once the difference becomes appreciated. Impressions and influences are received according to what it experiences in its social milieu. Words such as big, strong, pretty, delicate, good, bad begin to exert their effects. These are responses. A neighborhood delinquent, for example, when asked why he behaves as he does when he really seems such a bright, capable boy replies, "Everybody thinks I am bad so I may as well act bad." To present the other side of the coin, he continues, "Gee, you're nice. If you were my mother I wouldn't be bad." So the body-image is formed. And so it forms the individual.

Even from the foregoing abbreviated development it becomes clear that the factors contributing to the formation of the body-image are legion. Every experience is an influence, every variation of circumstances, for whatever reason, has its effect. Breaking the body-image down into some of its components, as referred to previously, Feldenkrais puts it more specifically: ". . . the relation of an organism to the world is made through sets of sensory-motor-vegetative reactions." Since there is no physiological separation of these elements, stimulation of any one must evoke a reaction in the others. The senses being fundamental to our contact with the outside world, the body-image is necessarily subject to ready change on that basis alone. A sharp sound startles, jerks the head, at least, perhaps moves the entire body. The smell of food sets up a whole chain of events. There is always an associated emotional state aroused. (Consider the state induced in a man who catches the odor of a perfume he has learned to associate with his sweetheart). Of course, in these instances the reactions are of short duration. Their nature depends upon the association patterns formed from previous experiences. Yet the same sort of conditioned response, in other circumstances, can cause more persevering changes in the body-image.

One contact medium with the outside world is the foot. With respect to the development of the postural body, Schilder says "that those parts of our body which come in a close and varied contact with reality are the most important ones. The foot gives us the most intimate touch with the earth." Feldenkrais, too, makes reference to the feet. In fact he does so repeatedly in connection with posture, neurosis and pain. And well he should! When about seventy percent[5] of public school children and at least eighty percent of adults show evidence of foot disorders, this is indeed a factor for consideration. Women, of course, suffer more with their feet by reason of the additional aggravation from their high heels and more highly styled, tighter shoes. The increased pressure is in itself sufficient to cause a bombardment of discomforting stimuli. But nature, to preserve the species, has its compensatory mechanisms so that ultimately, the persistent discomfort will be subverted from the stream of consciousness, though not without toll. It is for this reason women can usually insist that their tight shoes do not bother them. So far as they are aware, it is true.

Commonly, however, they develop calluses on the balls of their feet. Eventually these metatarsal calluses thicken to the point

of producing pain that is no longer to be ignored. Pain produces tension and anxiety. Anxiety alters the body-image. Since the condition is chronic in degree now (though likely acute in nature), the alteration pattern is likewise enduring. In addition, since no body condition remains static or improves unless forces are brought to bear to accomplish these ends, it becomes a progressively deteriorating matter. The intimate relationships of the components of the body-image gradually become more ramifyingly disturbed.

As a result of the pain, the body posture changes for the worse. Physical fatigue sets in causing a tired feeling. This is the result of two factors set into operation by the pain. First, there is the instinctive reaction to withdraw in the same manner as would occur with a pebble in the shoe. But since withdrawal from unpleasant stimuli is a total body reaction, all the defense mechanisms are incited to act. This includes the alerted action of the flexor muscle groups, with corresponding inhibition of the anti-gravity extensors. Hence it may be observed that poor posture accompanies the limp until the pain disappears following removal of the pebble. In the case of the metatarsal calluses, however, the tissue changes being chronic, there is constant call for the defense mechanisms. Now the second factor is called into play, namely, the conscious overriding control.

Awareness of the immediate cause of the discomfort coupled with the procrastination of necessary action creates the desire to ignore the problem. So orders contradictory to the normal defense pattern are relayed to the system. The conscious control now forces the voluntary nervous system into conflict with the reflex mechanisms. Thus the stage is set for superimposed nervous and psychic fatigue because nothing is done to change the original stimulus from the feet and the mind knows it. (In the interest of simplicity, the fuller aspects of the stress situation, a la Selye, are being deliberately overlooked.) Translating this into the family situation, consider what may happen. One of the first acts of the woman entering home is to get out of her shoes and either go barefoot or don other footwear. Our civilized surfaces are far from optimal for feet, and slippers or broken-down old shoes are worse yet for the additional deforming pressures they impose. In any event, while the sensation may be changed temporarily, the basic problem is still present and continues to exert the influences described. By the end of the day, when the husband arrives, the wife is tired and irritable, knowingly or not. (Certainly there are women whose inherent and acquired make-up can permit them to withstand the given circumstances with relative impunity. But that is not the usual case.) So, when he arrives, if what the husband sees in his wife causes a reaction either in his countenance or his remarks, it is no wonder that she explodes into the "you take care of the kids and cleaning and shopping and cooking, on your feet all day, and I'll go to work" type of argument. Then the bickering is on. If, on top of this, the husband himself is tired or has had a poor day, need more be said?

Of course, the feet need not be brought into the picture directly. Nor need the woman even be consciously aware by this time that they are bothering her. The toll of the body is exacted anyway, the body-image and self-concept are detrimentally altered, the fatigue level is still present, the woman still is operating on a relatively inefficient and anxious, sensitive plane. It may be only a chance, innocently tendered remark that could touch off the fireworks. It happens. How the stage is set for it to happen is illustrated by what follows. A patient, in all seriousness, tells the story of why it is not necessary to send

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her notices of when she is due in for further care. Her son says to her, "Mom, you better go get your feet fixed; you're getting grouchy."

Taking a different situation, picture a childless couple on another rung of the social ladder. They are better off economically and culturally, have no accessory factors contributing to friction such as in the earlier case. The same chronic foot disorder exists, however, having been present latently at least, since childhood years. The defense pattern of flexor contraction is so well established that even the toes are contracted. Of course, as indicated before, this local manifestation is only part of the complete picture. Now when this husband comes home (earlier than the other one), he is greeted by a wife who has just freshened up for him. There may be a cocktail or two prepared before dinner. The conversation is in keeping with the background of the couple. But does all this change the fundamental process operating within this woman with respect to her feet? No, it is merely that expression of the difficulty is in evidence in interactions on other levels which are more subtle. One important one, for example, is in the sexual relationships.

The fatigue factor, for one thing, can be sufficient to create a stronger desire for sleep. If the resulting lack of interest can still be overcome, cooperation may be of a distinctly low order from an attitude of "let's get it over with," conscious or subconscious. From a more physical viewpoint, however, there is an inability to obtain a completely satisfactory orgasm. As a result of the pattern of conscious overriding control mentioned earlier, there is "habitual contraction of the pyriformis, gemelli and gluteal muscles." (This is also part of the picture present in the out-toeing gait of the weakfoot generally associated with the metatarsal problem under discussion.) Consequently, there is distinct hindrance of the total muscular contraction necessary to complete orgasm. Yet another factor operates to forestall complete gratification: the anxiety caused by the pain-producing mechanism, the combination conditioned into coexistence almost from birth itself. It serves also to inhibit gratification. Then, too, the muscular ineptness interferes with coordination. In the face of these conditions, there may be a compensatory attempt to strive all the harder for fuller satisfaction. This causes further tightening of the conscious control to complete the cycle. (In this wise, Darwin once won a wager in which some gentlemen took snuff with the intent to sneeze thereby, but failed because of the intense desire to do so.)

Proceeding now to the senior citizens, the culminating effects of the foot problems in their relationships is more readily and directly demonstrable. The major concern of this group is health. At this point it is finally realized how much good health really means. And, too late, usually, the foot comes in for its fair share of attention. For too often, in these age brackets, foot problems are responsible for decided disability. Occasionally they become involved in the death of the person. There may be more significance than imagined in the application of the term "old ladies' shoes" to what these women usually wear.

As the foot problems of the aged reach the level of causing inactivity, there is a corresponding feeling of ueslessness and dejection. Observers may note that this change in attitude marks the beginning of the road from senescence to death. (To forestall this attitude is one of the major reasons why doctors today prefer not to banish a man to a workless position following a heart attack.) Mason notes that though studies reported in the literature are not in agreement, "much evidence appears to indicate that the problems encountered by the aged significantly influ-

ence and in some cases actually alter the level of adjustment. This influence appears to be related primarily to the individual's feeling of his own self-worth and, as a consequence, can be seen on the individual's self-concept."

When one becomes downtrodden in spirits, it is easy to see that the mate is bound to suffer as well. One patient with a heart condition found it necessary to call more frequently for the doctor as a result of anxiety over the confinement to bed of the diabetic spouse who had gangrene of the toes. Another had to run to out-of-town relatives to recuperate from rapid loss of weight incurred as the irritability and demands of the spouse increased with inactivity precipitated by disability from arthritis in the legs. But the outstanding example is the patient who burst into copious tears in the office one day. When asked what was wrong, she replied that she wished she were dead. Pursuit of the matter established that, though otherwise in acceptable health, her feet bothered her so much that she could no longer get about very well and, as a result, felt that she was such a burden to her daughter she no longer wanted to live. She died within that year.

Though the gamut from babyhood to the aged has been necessarily cursory, it is hoped that sufficient information has been brought to bear to establish the thought implied in the title: that the foot plays an important enough role in human relationships to be worthy of some deep consideration.

For the sake of discussion, now let it be assumed that the whole idea is being pursued to extremes in its effects on these human relationships. The very least that can be accepted, then, is that foot problems are a factor influencing the whole individual to some degree, however minor. The incidence, however, makes it quantitatively major. It is the qualitative factor being pursued here, though, since the quantitative speaks for itself.

It must be conceded that a relatively minor problem, such as a corn or callus, can intrude upon the stream of consciousness. Nobody who has had pain from either overgrowth will disagree. And certainly no podiatrist who has seen a patient limp in, virtually in tears from a lowly corn, will question the concession. The patient says she is in pain all over. Or she presses a fist to her stomach or heart saying it hurts even there. To these foot specialists, the remark, "When my feet hurt, I hurt all over," is actually a cliche. Yet this is truth to possibly the point of disbelief considering actual developments such as those presented. These people just do not know how much they really are "hurting."

Some say the head position exerts the prime influence over posture, some the pelvis, others the foot. Since, however, agreement is general that malposition of any of the three produces malalignment of the others in the total effect of poor posture, it is immaterial to this paper which comes first. The net effect is still the same. Kendall,[6] by his illustrations, points out this posture relationship even better than Goldthwait[7] or Phelps.[8] Nevertheless, the foot factor has been selected because of definite leanings in that direction. Such sentiments arise not only on the basis of the great incidence of foot disorders mentioned earlier. Still more fundamental is the reason for the stastics. That reason must be based, in part at least, on the overwhelming abuse accorded these extremities by the requirements of our civilization (to say nothing of the neglect), to an extent met by no other organ of the body. It is hoped, then, that this paper contributes a bit toward a clearer understanding of the reason for more deserving consideration of the foot as an important factor in the interrelationship of man and his society.

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Summary

1. The concepts of body-image and postural model of the body are briefly developed.
2. In relation to these concepts, the role of the foot is discussed.
3. With special reference to the married female, the mechanism of ramifications of foot problems affecting the personal relationships of the subjects is elaborated upon from the viewpoint of the body-image and self-concepts.
4. Further reasons are thus established to propound the idea that the foot deserves greater consideration as an important factor in the capacity of the individual to attain maximum enjoyment of life.

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References

1. Feldenkrais, M.: *Body and Mature Behavior*, New York, International Universities Press, 1949.

2. Wikler, S. J.: *Your Feet Are Killing You*, New York, Frederick Fell, Inc., 1953.

3. Schilder, P.: *The Image and Appearance of the Human Body*, New York, International Universities Press, 1950.

4. Mason, E. P.: *Some Correlates of Self-Judgment of the Aged*, Washington University Ph.D. Dissertation, St. Louis, Mo., January, 1954.

5. Statistics from records of the American Podiatry Association, 3301 16th Street, N.W., Washington 10, D.C.

6. Kendall, et al: *Posture and Pain*, Baltimore, Williams and Wilkins Co., 1952.

7. Goldthwait, et al: *Essentials of Body Mechanics*, Philadelphia, J. B. Lippincott Co., 1952.

8. Phelps, et al: *Diagnosis and Treatment of Postural Defects*, Springfield, Charles C. Thomas, 1956.

9. Rehabilitation Service Series No. 210: *Psychological Aspects of Physical Disability*, Supt. of Documents, Washington, D. C.

10. Aronow, R.: *The Foot in Body Mechanics and Health Maintenance*, Current Chiropody, 7:6-8, Feb., 1956.

EASY CLINICAL PHOTOGRAPHY

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THE purpose of this paper is to suggest the value of photography in our profession and a method of obtaining good results. Photographs simplify many phases of presentation, are useful for teaching, for consultation, for progress analysis, for illustrations, and for the keeping of permanent records.

If an ordinary picture is worth a thousand words, then in medical photography, the value is probably 20,000 words. This is due to the fact that our medical vocabulary for describing conditions is extremely inadequate, and that from description alone, many conditions seem alike. One photograph rises above the barrier of language limitations. The condition can be seen instantly. A ptcture is a universal communication understood by everyone.

The careful practitioner treats his patients under conditions as sterile as possible. Unless he and the patient have a great amount of time to spend on treatment and recording he must stop the procedure to pick up his camera, figure his settings and take the picture. He must then take care to resterilize before he resumes treatment.

The practitioner therefore prefers a simplified method, which does not interrupt his work, and which can easily be entrusted to his nurse or assistant. This can be accomplished by the use of a preset standardized camera with a simplified focusing device and a "Press the Button" technique.

The most versatile camera for our work is the 35 mm single lens reflex camera. It allows you to see exactly what you will photograph by focusing the image on ground glass. One need not get into ex-

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pensive cameras to obtain good results. My camera of choice is the inexpensive "single lens reflex" type with "Strobe" light synchronization sockets for flash photography.

Single lens reflex photography is considered the "Grandfather of all closeup photography," but has been complicated by the many gadgets and accessories needed. This is no longer the problem as there are non-commercial units that, by simplifying and modernizing the accessories, make "single reflex" photography practical even in offices where time is of the essence.

The right combination of lens, shutter, picture area, correct exposure, lighting and proper accessories results in good photography. Let us take these item by item.

The Lens—It is the lens that "sees the picture" and then transmits the image to the sensitive film in your camera. Speed or light passing ability of a lens is rated by "F" numbers—the lower the number the larger its opening and the greater its light passing ability. Lenses with considerable light passing ability usually have a diaphragm within them so that they may be "closed down" when you want less light to pass. Image size is governed by the focal length—the distance from the lens to the film when the lens is focused on a distant point.

The Shutter—The door in your camera is called the "shutter." There are several different kinds of shutters, but all serve the same purpose, that of letting light reach the film for a specific length of time. A frequently used shutter speed is 1/50th of a second. The slower the shutter speed, the greater the amount of light that passes through the lens. Colored slides are usually taken at 1/25th of a second, black and whites at 1/50th. At these speeds, a tripod is useful to prevent blurry photos due to camera movement. The tripod gives your camera the necessary steadiness to make your photos sharp and clear.

Picture Area—The reflex finder shows exactly what will be recorded on film. Focusing the image on the ground glass yields the most accurate picture. You actually see the image and adjust the lens until the image is in sharpest focus.

Correct Exposure—The same kind of film must receive comparable amounts of light or "exposure" in order to record the same quality of image on the film. This is accomplished by correlating the size of the lens opening ("F" number) to the length of time it will be uncovered (shutter speed).

Lighting—A good picture requires just the right amount of light to reach the film. Flash units are compact and light-weight for convenient carrying. They are packed with power for peak efficiency and their light output is constant. "Strobe" lighting is a light of such short duration that it will freeze motion and will yield "action" pictures with the definition of a "still." Since its specular quality is very similar to daylight, it is well suited for use with daylight color films. "Strobe" lighting by electronic flash produces a soft light that penetrates deep in the background without burning up the foreground, yields excellent renditions of features and textures, fast enough to eliminate camera movement problems.

The ring light, a more modern adaptation of the electronic flash, is assuming a multipurpose photographic use in medical work. Its great flexibility and adaptability indicates that electronic ring lighting will be the photographic light of the future. The ring light fits around the lens of any camera; it gives clear, sharp, shadowless close-up pictures in both black and white and in color work. It can be used within inches of the object to be photographed.

Portrait Lenses—This can be an inexpensive accessory for distances ranging from three to nine inches between the subject and the lens. With these, one can effect

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stronger magnification, yielding greater detail.

"Safe-Set"—The need for a standardized system of taking pictures with the above-mentioned equipment leads us to the "Safe-Set" factors. The "Safe-Set" factors can be coordinated to make a perfect exposure, and prevent forgetting something at the exact instant the picture is to be taken. Using the letters "S-A-F-E," the following check method is suggested: "S"—Shutter speed set. "A"—Aperture set. "F"—Focus adjusted. "E" —Effect.

With the above standardized presetting method, we have just to "push the button" to take a perfect picture.

Prints—Making positive prints for publications is best accomplished by sending the colored transparencies to commercial processing companies in your locale, requesting glossy black and white 5x7 or 8x10 prints for use in periodical publications.

Suggested text and references:

"A Guide to Medical and Dental Photography" by Kenneth S. Tydings, S.P.E., Greenberg Publisher, N. Y.

"Speedlight Center," 128 W. 32nd St., N. Y., Medical Dental Scientific Photographic Equipment Co., Box 55, Leviton, N. Y.

Hershey Mfg. Co., 135 So. LaSalle St., Chicago 3, Ill.

Exa Camera Co., 705 Bronx River Rd., Bronxville 8, N. Y.

6135 Wilshire Blvd.

A CLINICAL REPORT OF ATYPICAL DERMOID CYST

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Dermoid cysts appear along the lines of embryonic fusion and develop from inclusion of displaced dermal cells along these lines. Histologically, their walls are thick and fibrous, lined with squamous epithelium which resembles skin; they usually contain hair follicles and sebaceous and sweat glands. The contents of the cysts are cheesy, sebaceous-like material, at times mixed with hair. Only very rarely are other structures, such as cartilage and bone, to be found in them. In many cases, a sinus may be noticed, through which the contents of the cyst may be expressed.[1]

Epidermoid cysts exhibit a smooth external surface and a cavity lined by stratified squamous epithelium, the cornified layer being adjacent to the cavity of the cyst. Epidermoids consist of squamous epithelium only; when skin appendages are present the growth is called a dermoid. The external surface of the tumor is avascular and has a pearly appearance. Because of their high content of cholesterol these growths have been incorrectly called cholesteatoma.[2]

DuVries[3] states that an epidermal cyst is an encapsulated mass filled with caseous material; it is often erroneously called sebaceous cyst. Epidermal cysts appear on any part of the body, oftenest on the scalp, occasionally on the plantar surface of the foot. There are no sebaceous glands in the plantar surface; hence, sebaceous cysts cannot form there. Epidermal cysts on the plantar surface vary in size from 0.5 to 3.0 cm. They are painful only when they appear on a weight-bearing surface, such as on the ball of the foot. They are extremely

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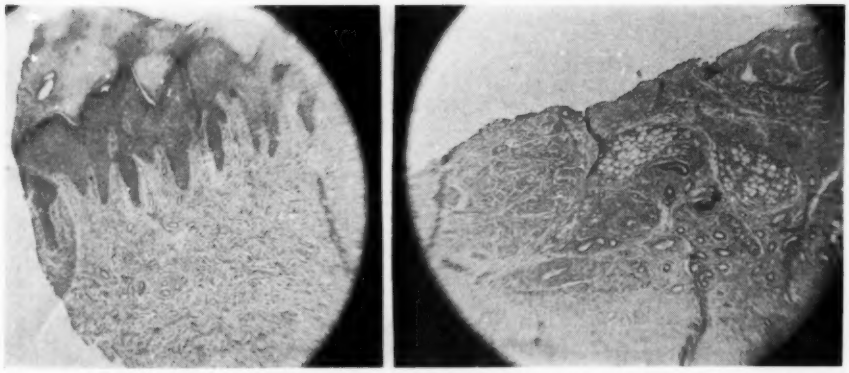

Fig. 1—Photomicrograph of dermoid cyst showing evidence of thickened and hornified epithelium with elements of skin appendages. Hematoxylin and Eosin Stain (x400).

painful under a metatarsal head, as if a pebble were in the sole of the foot. Epidermal cysts are often erroneously diagnosed because they are relatively uncommon and because the skin surface may appear normal. A diagnosis is made by finding, on palpation, a freely movable circumscribed subdermal mass of medium hardness.

An adventitious bursa under the first metatarsal head is an accumulation of lobular bursal tissue under the great toe joint. The accumulation often reaches massive size. It is observed most in girls during adolescence or in early adult life. It is due to a chain of conditions, such as hypermobile sesamoids, sesamoids that are articulate immediately under the great toe joint space, and bifurcated tibial sesamoid, especially if that bone is distorted or abnormal in size. These factors, in combination with the wearing of high-heeled shoes before the sesamoids have completely ossified, and excessive dancing and pivoting on the first metatarsophalangeal joint cause the defensive formation of a bursa. On palpation, the mass feels like a large bulbous structure under the skin, which is freely movable and compressible.[4]

Silverman and Kove[5] in 1959 described a case of atypical epidermoid cyst, on a male complaining of pain in the ball of the right foot, plantar metatarsals 2-3-4. Operation disclosed a 2.5 x 3.0 cm growth under the heads of metatarsals 2-3-4 which was pathologically diagnosed as epidermoid cyst.

Case Report

A patient, male, 56 years of age, presented himself to the podiatry clinic at Harlem Valley State Hospital, complaining of a painful corn, plantar aspect of the first metatarsal head, right foot. Examination of the part revealed a plantar heloma durum over a moderately sized, circumscribed soft tissue swelling of medium hardness. The area was painful on weight-bearing and on digital pressure. The subdermal mass was round and freely movable. There was no known history of injury or trauma to the observed area. The patient's medical history was poor, having sustained a loss of weight and having pulmonary complications. The patient also had a suspected rheumatoid arthritic right knee.

The author's pre-operative diagnosis was made tentatively as an adventitious bursa, plantar aspect of the first metatarsal head, right foot. The operative technic of choice was excision of the "adventitious bursa" and a tibial sesamoidectomy.

The patient was placed on a nutritional and vitamin C (150 mg daily) regimen, two weeks preoperatively.

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Preoperative examination and laboratory findings were not significant. Roentgenograms were essentially negative for osseous changes. The preoperative medication was morphine sulphate, gr. 1/6; atropine sulphate, gr. 1/150; benadryl, 50 mg. P.O.

Operative Procedure: The patient was prepared for surgery with a 24 hour surgical skin prep. Local anesthesia was established by infiltrating the pathologic area with 9.0 cc of 2% Xylocaine HCl®[1] with 1:100,000 epinephrine. When anesthesia was obtained, a pneumatic tourniquet was placed on the upper thigh at 500 mm pressure for maximum hemostasis. An incision was made following the curve of the mediolantar border of the right great toe joint. The skin margin was retracted and a plantar flap was freed from the plantar surface of the great toe joint. The bulbous mass was exposed and dissected free. Some caseous-like material was observed exuding from the excised mass. A mediodorsal incision was made in the capsular ligament of the first metatarsophalangeal joint. The tibial sesamoid was then enucleated in toto by sharp dissection. The resultant wound was digitally explored for more pathologic tissue, and finding none, irrigated with warm sterile normal saline solution. The capsular ligament was closed with three interrupted sutures of 000 chromic catgut. Subcutaneous fascial closure was made with four interrupted sutures of 00 plain catgut. The skin was then closed with seven plain interrupted sutures of 000 black silk. Sterile vaseline gauze and pressure dressings were applied to the wound.

Postoperative Course: Rest and elevation of limb and weight-bearing after 48 hours were prescribed. Postoperative pain was minimal, healing was protracted for the first week by a hematoma. This was reduced by hydrotherapy and vitamin C (150 mg. daily) therapy. Sutures were removed on the seventh day. At this writing the patient has been transferred to another state hospital on Long Island.

Pathologist's Report: Gross Description—The specimen is about 2 x 2 cms in diameter. The outer layers are fat and fibrous tissue. These surround a nodular tumor, about 1 x 3/4 cm at all sides except one. The last surface is smooth and glistening. Centrally, there is a tiny cavity, about 2 mm in diameter.

Microscopic Description—The nodular tumor consists almost entirely of thickened and hornified epithelium of normal structure. The outer layers are fibrous tissue enclosing hyperplastic glandular structures (adnexae of the skin). Diagnosis—Dermoid cyst (benign).

®[1] Astra

Summary

1. A dermoid cyst was found in an area which is a more common site for an adventitious bursa.

2. The difficulties in diagnosis are discussed.

3. An explanation for the histogenesis of this occurrence is given.

4. The pathologist's report of the tissue examination was necessary to establish the diagnosis.

45 Hooker Ave.

References

1. Ferguson, L. K.: *Surgery of the Ambulatory Patient*, J. B. Lippincott Company, 2nd edition, Philadelphia, Pa., P. 190, 1947.

2. Bell, E. T.: *Textbook of Pathology*, Lea & Febiger, 6th edition, Philadelphia, Pa., P. 409, 1949.

3. DuVries, Henri L.: *Surgery of the Foot*, The C. V. Mosby Co., St. Louis, Mo., P. 196-197, 1959.

4. Ibid: P. 228.

5. Silverman, L. F., and Kove, I.: *Atypical Epidermoid Cyst, A Case Report*, J.A.P.A., Vol. 49, No. 10, P. 461-462, October, 1959.

"Thou shalt guide me with Thy counsel."

Psalms 73:4

TIBIAL NERVE BLOCK FOR PLANTAR ANESTHESIA

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ANESTHESIA of the sole of the foot by (posterior) tibial nerve block has many advantages, both obvious and subtle. There is need for this technique to be better known and more frequently utilized by podiatrists. There is also need for the adoption of a standard, reliable method for administration of tibial nerve block.

Podiatrists find it of value for anesthesia preparatory to plantar intra- or subcutaneous therapy such as the use of corticosteroid preparations for hyperkeratotic skin excrescences, and vitamin A or other injectables for plantar verrucae.

This technique is useful preparatory to clinical surgery, for the removal of foreign objects, debridement of various skin lesions, or skin planing. This use can be expanded, according to the practitioner's discretion, to include almost any instrumental therapy applied to the planta.

Nerve block is also suitable for plantar operative surgery, performed in office, clinic or hospital. The anesthesia produced is sufficiently profound for this use.

The most important reason for preference of the tibial nerve block to local infiltration or regional field block is that injection into thick, tough, plantar skin is obviated. Thus it is less painful, less traumatic, and less dangerous to the patient and less difficult to use.

Another advantage of tibial nerve block is the production of anesthetic over larger areas of tissue. As it is normally applied, the entire planta is anesthetized, with occasional exceptions due to anomalous nerve distribution. It is also possible to anesthetize large parts of the planta by blocking only branches of the tibial nerve, at the level of injection. This is applicable to the calcaneal branch, and to a lesser extent, to the medial and lateral plantar nerves.

Tibial nerve block is also occasionally used therapeutically, for treatment of calcaneal spurs, circulatory conditions, etc.

Tibial nerve block is performed best with the following materials. A 5cc. syringe, glass, of the Luer-lock type, is preferred by the author. Whatever type is used should be 5cc. capacity. For adults, a 1½-inch, 24-gauge needle is recommended; for children and adults with small feet, a 1-inch 25-gauge needle is sufficient and handier. The length of the needle is very important, since a comparatively large area must be covered from one site of injection. Where only the calcaneal branch is to be blocked, a 1-inch needle is long enough. A heavier gauge needle is unnecessary, and will only cause needless pain and trauma. The use of a topical anesthetic spray, such as ethyl chloride, is optional, since some individuals will be troubled more by the spray than the injection; however, it is useful with children, and with proper use of suggestion, can be very helpful psychologically.

The choice of anesthetic agent depends on the practitioner's preference. The strength, or concentration, should be equivalent to a 2% solution of procaine. The amount used is 4cc., whatever the choice of agent.

The site of injection is a point on the medial side of the heel, on a line corresponding to the posterior border of the laciniate ligament, just superior to the border between plantar and dorsal types of skin.

The posterior border of the laciniate ligament can be located by connecting the point of the heel and the medial malleolus. This corresponds to the structures con-

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nected by the ligament. In this area, there is the smallest amount of tissue between the skin and nerve, the amount depending on the sex and corpulence of the patient. It will be noticed that the plantar type of skin continues past the medial border of the heel, and forms part of the medial surface. Injection should not be made through this plantar-type skin, but is made just superior to it, on the imaginary line described above.

If it is desired to anesthetize only the anterior part of the foot, and not the heel, injection is made about ½-inch nearer the malleolus, to avoid the calcaneal branch. A 1-inch needle is used.

The direction of the needle is toward the malleolus, paralleling the posterior border of the laciniate ligament, and crossing the tibial nerve, and all the other structures which pass deep to the ligament. The angle of the needle, relative to the skin surface, changes at least twice. At first, for the original skin penetration, the needle is directed at the usual 25 degree angle, and the penetration is made with a quick thrust. The wheal is made, and the needle then lowered to a 5 degree or 10 degree angle, for subcutaneous injection. The needle is advanced toward the malleolus, with anesthetic injected in advance. If a full block is intended, the point should stop just short of the malleolus itself. If only the calcaneal branch is to be blocked, the needle should only penetrate ⅓ of the way to the malleolus.

After the superficial injection, the needle is withdrawn, to the point of insertion, but not completely out. The syringe is then elevated to a 20 degree angle, or 30 degrees if there is considerable adipose tissue; the needle is advanced again, the same distance as the more superficial injection. If the point of the needle strikes bone, the needle should be withdrawn slightly, and a more shallow angle used, unless the bone is the malleolus. This will complete the injection; there is only one skin puncture with this technique.

The amount of anesthetic used is as follows: about .25cc. for the skin wheal, 1.75cc. for the remainder of the superficial injection, and 2cc. for the deep injection. Total is 4cc. The above quantities are for adults; an appropriate reduction is made for children, according to size. Also, if only part of the nerve is blocked, a total of 3cc. is used for the medial and lateral plantar nerves, or 2cc. for the calcaneal branch. These quantities are divided equally for the superficial and deep injections, with .25cc. for the wheal in any case.

It is especially important, during the administration of the block, that the syringe be aspirated each time any amount of anesthetic is injected. This is particularly necessary during the deep injection, since the needle passes very close to the posterior tibial artery and veins. If blood is aspirated, injection must be discontinued. Since this will usually occur during the last part of the technique, anesthesia is usually obtained. Care should also be taken not to injure periosteum by repeatedly striking or scraping bone surface; this is more likely to occur on the medial side of the calcaneus. Finally, the practitioner should be prepared for any idiosyncrasy or other untoward reaction to the injection. It is good practice to have the patient supine.

The period of time it takes for the anesthesia to take effect is variable. Occasionally, there will be complete anesthesia almost immediately. Rarely does it take more than twenty-five minutes, with ten minutes being the usual. Anesthesia does not occur uniformly for all three areas of the planta, but the heel usually "goes" first, followed by the lateral and medial plantar nerve areas, in that order.

There are various signs of approaching local anesthesia. The first to appear are heat and redness, together. The heat is both subjective and objective. The redness

is usually quite pronounced. This is caused by the blockage of the vasomotor (constrictor) fibers of the tibial nerve, allowing the vessels to dilate. These signs may appear at any time before anesthesia, and are a good indication of the extent of anesthesia. The next sign that appears is paresthesia, almost immediately before anesthesia. This lasts a variable time, usually one to five minutes. Anesthesia appears, immediately following paresthesia, and becomes quite profound. The usual method of testing, with a sharp point, is adequate, providing the practitioner recognizes the diminution of sensitivity through hyperkeratotic areas.

Sometimes, after the onset of anesthesia, a transitory partial paralysis of the toes appears, due to the blockage of the motor fibers of the tibial nerve innervating the intrinsic plantar muscles. The patient will have difficulty flexing the toes. This phenomenon is harmless, and disappears when the anesthesia resolves.

Plantar anesthesia by tibial nerve block usually lasts about an hour, although it may last several hours. This is sufficient time to complete any procedure for which this method of anesthesia is suitable. The patient is able to walk with one foot anesthetized, with a slight limp. Sometimes the patient will seem to have difficulty putting on his shoe; it will not feel like the shoe is completely on the foot, because of the plantar insensibility. While walking the anesthetized foot will feel like it is literally walking on air. The patient must be cautioned against possibility of injuring the foot because of the lack of normal pain response.

There is usually very little or no post-injection pain or discomfort. Sometimes the period of dissolution of anesthesia will be annoying. This is relieved by non-weightbearing.

Summary

A technique of plantar anesthesia has been presented, which is effective, precise, and comparatively painless to administer. The technique, indications, and signs have been described.

A few anatomical facts might be renewed here. The skin of the plantar surface of the heel is supplied by the calcaneal branch of the tibial nerve. The skin of the plantar surface of the fifth toe, the lateral half of the fourth toe, and the area posterior to these, are supplied by the lateral plantar nerve. The remainder of the plantar skin is innervated by the medial plantar nerve. At the level of the laciniate ligament, the tibial nerve is ordinarily postero-inferior to the posterior tibial artery, with only occasional exceptions.

81 W. State Street

Reference

1. Schaeffer, J. Parsons, M.D., Ph.D.; *Morris' Human Anatomy;* Blakiston, New York, N. Y., 1953.

"A humble knowledge of thyself is a surer way to God than a deep search after learning."

—*Thomas à Kempis*

PATHOLOGICAL FRACTURES IN AN OLDER INDIVIDUAL

GEORGE R. GABRIEL, D.S.C., A.C.F.O.
EMIL S. BURGER, D.S.C., A.C.F.O.
Chicago, Ill.

THIS is a presentation of a case we considered to be pathological fractures related to senility and osteoporosis. A pathological fracture is interruption of the continuity of bone due to minimal trauma, usually occurring spontaneously at the site of diseased bone. [1,2,3] The common conditions associated with cases are senility, osteoporosis, osteomalacia, osteomyelitis, prolonged corticosteroid administration,[4] benign tumors, malignant tumors, X-ray and radium irradiation, hyperparathyroidism.[3] The senility in this case is a generalized decalcification of osseous structure occurring with the advancing years, due to decreased activity, hormonal changes, and deficient diet (particularly in regard to calcium). Fractures occur easily in the aged, at the hip and at other weight bearing bones.[2] The osteoporosis is related to such factors as sex hormone deficiency, improper nutrition, disuse atrophy, etc., causing a decrease in bony matrix. There is enlargement of the bony canals principally in the upper ends of the femora, the humeri, the lower ends of the radii, and the ends of the long bones of the feet.[3] These bones are highly susceptible to fractures, even to slight trauma. This is of much significance in the long bones of the feet, since the feet are subjected to the great stresses of stance and locomotion.[5]

About one-third of the skeletal volume or 40 per cent of the mineral content is lost before bone resorption by X-ray is apparent.[6] When the X-ray shows a lighter than normal shadow, with a more distinct cortical outline, and opalescence of the bone, this is evidence of moderate osteoporosis.[2]

Osteoporosis is primarily a structural change in which there is a reduced amount of supportive tissue in the bone, with a maintenance of adequate mineralization of the available bone matrix. In health, bone is laid down by the osteoblasts, and resorbed by the osteoclasts, but in osteoporosis, bone formation is at a minimum, because of diminished osteoblastic activity.

The osteoclasts continue to function normally in resorbing bone and its mineral components, and with reduced bone production, a weakening of the bone structure results.[2] Osteoclasts respond to injury with greater activity than osteoblasts; and, therefore, bone resorption occurs. The ratio of bone destruction to production may be as high as 70:1. [7,8]

Case History: Female, age 81; height 5 feet, weight 90 lbs. Past medical history: Has had no physical examination for the past 3 years. There is a past history of allergy, primarily to chocolate, milk, wheat and eggs. Patient's diet was supplemented with a calcium preparation, which had not been taken regularly. There was an incident of gout several years ago, with no recurrence. At present, she has usual complaints of an older individual, and joint discomfort affected by weather changes.

Present complaint: September 12, 1959, while walking, patient twisted slightly the right foot and ankle, and has since developed increasing swelling, pain, heat and redness of the right foot.

Examination: Right foot was severely swollen from toes to ankle region. On weightbearing there is extreme rear foot valgus, bilateral. The extensive swelling in the right foot does not permit toes to make contact with the ground.

Fig. 1—Serial radiographs of the case reported. Left, 10-31-59; Center, 11-23-59; Right, 4-21-60.

This is a geriatric patient with no unusual generalized physical complaints; mentally alert and physically active. Blood pressure, 160/90. Dorsalis pedis, posterior tibial, anterior tibial arteries were palpable and equal. Oscillometric readings were: left calf, 1¼. Right calf, 1¼. Above left ankle, 1. Above right ankle, 1.

Neurological findings: Pin pricking tests in the feet greatly diminished. Patient describes sensation of the feet and limbs as feeling numb. Patellar, Achilles and Babinski reflexes all hypotonic but equal.

Laboratory findings: Sedimentation rate, 16 mm at the end of 60 minutes (Westergren normal 0-15 mm). Blood sugar, 86.0 mg. per 100 cc blood. Uric acid, 3.2 mg. per 100 cc blood. Hemoglobin, 80.9%. White count, 6,300; Red count, 4,140,000. Differential neutrophiles, 57%; Lymphocytes, 36%; Basophiles, 1%; Eosinophiles, 3%; Monocytes, 3%.

Urinalysis: Sugar, negative. Albumen, 1 plus. Specific Gravity, 1.010. Color, light straw. Appearance, minimal sediment. Reaction, pH 6. Odor, normally aromatic.

X-ray examination including both feet and legs reveals generalized demineralization with evidence of an old healed fracture at the neck and upper shaft of the second metatarsal bone, right foot. There is an interruption in the continuity of the third metatarsal head and neck, with some displacement posteriorly of the head.

Interpretation: Complete fracture of the third metatarsal at the region of the head and neck.

Treatment: Patient was kept semi-ambulatory, given hydrotherapy, ultrasound in minimal dosage, 0.5 watt per square cm. 8 minutes every 2 days.[9] A forefoot taping, and figure eight bandage was used for 3 weeks. A heavy soled ten-eighths heel, six eyelet oxford shoe added to the control of the fracture support. Patient was equipped with a cane, and minimal ambulation permitted. Therapeutic vitamins, and a high dosage calcium gluconate supplement for dietary insufficiency were prescribed.

On October 31, 1959, while patient was entering taxicab, she heard a snap-like sound, and immediately felt pain approximating the fourth metatarsal head of the right foot. Patient was confined to total bed rest for the next 2 days. X-rays of 10/31/59 were negative (Fig. 1. Left). However, X-rays of 11/23/59 (Fig. 1. Center) revealed a fracture of the fourth metatarsal neck, similar to the original fracture

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of the third metatarsal neck of the same foot. (This is the typical fracture pattern of minimal trauma in the senile osteoporotic patient.) Treatment continued with immobilization of the foot and ankle, hydrotherapy, ultrasound, with vitamin and high calcium supplement.

From 10/1/59 to 12/22/59 patient was seen 3 times a week. From 12/22/59 to 2/23/60, twice weekly. The bandaging was replaced with a strong removable elastic foot and ankle support. Progress was excellent, with good healing of the fractures. Severe swelling remained for about 2 months, and at present the right foot is of normal appearance.

Follow-up examination and X-rays on 4/21/60 (Fig 1. Right). Good function, no swelling, full activity. Fracture sites show good healing and alignment.

Resumé: In view of the above findings, it was decided that while it is controversial, casting a gerontal patient has various undesirable factors.[6] In this case, good control was maintained by semi-ambulation, plus patient cooperation, with avoidance of secondary serious effects of static inactivity such as respiratory depression, kidney dysfunction and decreased appetite.[8] Patient was mentally alert and would follow explicit direction. The excellent end results of this therapy justify our decision.

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References

1. Schreiber, L. F.: *Bone Fragility and Stress Fractures*, Current Podiatry, Pages 21-22, April, 1959.
2. Therapia, Hoffman, LaRoche, Inc.: No. 68, *Osteoporosis*, Pages 1-10, August, 1956.
3. Lieboldt, F. L.: *Fracture Treatment*, Lange Medical Publications, Los Altos, California, Page 6, First Edition, 1954.
4. Sheldon, J.: *A Rounded Approach to Asthma Therapy, Prolonged Corticosteroid Therapy*, Page 25, Seminar Report, Winter, 1959.
5. Roberts, J., Kelly, J.: *Treatise on Fractures*, J. B. Lippincott Co., Pages 5-7 and 86-87, 1921.
6. Demy, N. G.: *Factors Influencing Bone Density*, Page 8, Seminar Report, Winter, 1959.
7. Demy, N. G.: *Factors Influencing Bone Density*, Page 10, Seminar Report, Winter, 1959.
8. Sante, L. R.: *Principle of Roentgenological Interpretation*, Edwards Brothers, Inc., Ann Arbor, Michigan, 1947, Pages 74-75.
9. Birtcher Medical Foundation, Medical Ultrasonics in a Nutshell, Treatment of Fractures with Ultrasound, Page 17, 1957.

"One ought every day at least
to see a fine picture, to read a
little poem, to sing a little song
and, if it were possible, to speak
a few reasonable words."

John Ruskin

CLINICALLY SPEAKING

A place for the more informal presentation of reminders, suggestions, notes, observations and technics of value in office practice. Your contributions of short manuscripts or illustrative case histories will determine this section's usefulness.

ENLARGEMENT AND DISPLACEMENT OF A LATERAL SESAMOID

A Case Report

VICTOR J. RAINERI, Pod.D.
Syracuse, N. Y.

A WHITE, female patient, age 48, married, presented herself in my office complaining of a severe and unrelenting pain in her right forefoot.

In her history, she gave the onset as a sudden, sharp pain which occurred two months ago, while at work as a checker at a food market, which occupation kept her continuously on her feet. The pain gradually disappeared by the next day, but began recurring with the same suddenness every three or four days. After a few weeks, the attacks occurred with greater frequency, became more painful, and lasted longer Recently, the pain had become almost continuous and she was forced to discontinue working. At this time, she also complained of "feeling something roll around inside my foot" on weightbearing.

The general appearance of the patient was one of normal contour and weight. She walked with a distinct limp and was unable to bear weight on her right foot for more than a few minutes at a time. Examination of the foot revealed nothing in the skin or in the immediate subcutaneous tissue. A moderate hallux valgus was present and deep palpation of the area between the first and second metatarsal heads elicited acute pain. Also palpable, at times, was a slightly movable mass which could be moved only laterally and medially, but not in any other direction. X-rays showed some lateral displacement of the fibular sesamoid bone of about one-half its width into the metatarsal interspace. There was no evidence of a tumor. The impression at this time was that the symptoms were due to a displacement of the lateral sesamoid bone which, intermittently, became displaced to a greater degree under certain conditions of stress on weightbearing. The possibility of a neoplastic mass about or near one of the branches of the medial plantar nerve was not, however, eliminated.

The patient was placed on a regimen of palliative treatment to try to give some relief. Metatarsal paddings, proper fitting flatheeled oxfords, Thomas bars, and injections of hydrocortisone and procaine were tried, but none gave any appreciable relief. The patient seemed gratified when a decision to operate was announced. It was explained to her that the operation was intended to explore the first and second metatarsal interspace and adjacent areas and, if no pathology was noted there, to excise the lateral sesamoid which was considered to be the prime offender.

The patient was then admitted into the hospital. All laboratory and physical findings were in the normal range. Under general anesthesia an incision was made on the dorsum, extending posteriorly from the web of the first interdigital space, lateral to the tendon of the extensor hallucis longus to the distal end of the proximal third of the first metatarsal bone. The incision was deepened to expose the first and second metatarsal heads. These were spread slightly with retractors, and the entime interspace area was explored without result. The lateral sesamoid was not visible, apparently being withdrawn under

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the head of the first metatarsal. The Adductor hallucis brevis tendon was severed from its insertion into the base of the proximal phalanx of the first toe and grasped with an Allis clamp.

Pull on the "stub" brought the sesamoid partly into view. The difficult and tedious dissection of the sesamoid was accomplished by grasping it with a small towel clamp and dissecting it from both ends with a #15 blade scalpel and small curved scissors. Care was taken to preserve the integrity of the tendon. With the excision completed, it was found that the moderate hallux valgus was corrected. The adjacent sides of the first and second metatarsophalangeal joint capsules were sutured together with four interrupted 000 chromic sutures. The subcutaneous tissue was approximated with three 000 plain catgut sutures, and the skin was coaptated with five vertical mattress sutures of 000 silk. A compression bandage was applied over sterile Telfa®[1] and gauze dressings.

Ambulation was started on the third day and the sutures were removed on the eighth day. One month from the date of surgery, the patient returned to work on a part-time basis. Within 2 weeks, she began working full-time. At this writing, which is 5 months post-operatively, she has been doing her usual work and has remained completely free from pain.

A gross examination of the excised sesamoid bone showed it to be much more enlarged, dorsoplantarly, than appeared on the X-rays. The original symptoms were probably due to intermittent displacement of the enlarged bone into the interspace. It seems that the pivoting action of the foot on an enlarged sesamoid, coupled with short shoes, caused the lateral sesamoid bone to move from its site.

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MEDICAL RELAXATION FOR A SPASTIC GASTROCNEMIUS

A Case Report

ALAN I. SULKES, D.S.C.

A YOUNG man, age 16, presented himself in the office with severely spastic gastrocnemius of the right leg. The muscle was very hard and very painful. Routine physical therapy such as massage, heat, ultrasound, whirlpool, etc., produced no results. Medical relaxation seemed to offer possibilities, and parental permission was obtained.

The process was explained to the patient. We then first induced a somnambulistic state of relaxation. The suggestion was made to the patient that as the affected part was stroked he would feel the muscle relaxing, and the pain subsiding. This was done, and under our fingers we could feel the muscle spasm relax and soften. Keeping the patient in this state, we had him walk around and then do 10 deep knee bends, with no recurrence of the spasm. After suggesting that there would be no discomfort or pain later, and giving the patient the good health suggestions, he was brought out of the relaxed state. His spasm had completely disappeared and he had no discomfort in the area and has not since.

The entire process from induction to dismissal took 12 minutes.

Comments

Medical relaxation has a great potentiality in podiatry. However, it must be used carefully and with great discrimination. The operator should not attempt to use medical relaxation until he has completed a training course given by a qualified instructor.

2011 E. 75 Street

AN EMPIRICAL TREATMENT FOR MOSAIC VERRUCAE

HYMAN LIEBERMAN, Pod.D.*
Brooklyn, N. Y.

MEMBERS of the healing arts are constantly seeking effective treatments and cures. Some treatments are called specific and others are known as empirical. Both are acceptable if they effectuate a cure.

In 20 years the author's experience has been that mosaic verruca are the most stubborn of all ailments in his practice. This type of verruca usually resists all forms of treatment including surgery, actual and chemical cautery, and radiation therapy.

About 3 years ago, the author noting the reports of Vitamin A as an excellent adjunct in the treatment of skin ailments started this study. This report describes an empirical treatment for mosaic verrucae, based on 165 positive results out of 180 cases.

The average case of mosaic verrucae usually requires 6 to 18 months of therapy when the various chemical and physical methods are used. Such was the author's experience using 60% salicylic acid during a summer "hot spell." The patients were instructed to keep the treated areas dry, but, contrary to instructions, these patients went swimming in the ocean because of extreme hot weather. It appeared that the salt water had an effect on the verrucae and caused complete resolution of the growths. All patients were then instructed to purchase "sea salt" and soak their feet daily. Some of the cases responded, but the majority failed to do so.

Going a step further, Vitamin A+, 50,000 units for children, and 100,000 units for adults, was added to the diet of the patients. This produced unusually good results. With further experimentation empirical treatment for mosaic verrucae was developed which in the writer's experience seems almost specific. The following is the treatment which has produced 165 positive results out of 180 cases.

The verrucae are pared until slight hemorrhage occurs and cauterized with silver nitrate. The foot or feet are then immersed in a solution of sea salt (½ cup of sea salt to a quart of warm water) for 15 minutes. The vitamin A is taken orally, daily. The patient is seen once a week and the treatment is repeated. In many instances, only one or two treatments were necessary. In most cases, the average cure took place within 2 to 10 weeks. In the last stage, the mosaic verruca appears like a bluish hematoma which when removed, leaves clean, pink, normal tissue.

Children seem to respond more rapidly than adults. Multiple verrucae (non-mosaic) have been treated with the same method with slightly poorer results. Single non-mosaic verrucae do not respond as well, but some successes were noted.

134 Sutter Avenue

•Chief Podiatrist, Beth-El Hospital.

†Tabalin A, Dalin Pharmaceuticals, Inc., and Aquasol A. U. S. Vitamins were prescribed.

"No man is an Iland, intire of itself;
Every man is a peece of the Continent, a
part of the maine."

John Donne

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A. RUBIN, D.S.C., Editor

Communications regarding manuscripts, news items, and editorial matters should be addressed to the Editor, those regarding advertising to the National Advertising Representative.

PRESIDENT'S INAUGURAL ADDRESS

As I step upon the threshold of the coming year's activity and approach the Presidency of your organization, I do so in all humbleness and certainly not without a considerable amount of trepidation, knowing full well the responsibilities it entails. However, on second thought, I become fully aware that, after all, this is not a one-man job—for on each side of me stand the experience and the determination of a dedicated group of people; namely, the officers and trustees upon whom one can certainly depend for guidance and assistance—likewise all those who make up the membership of all the active committees throughout the country. My sincere prayer is that Almighty God will enlighten us so that we may complete a worthy task for the profession and the people it serves.

There are many facets of our profession and our organization which I should like to discuss with you, but, of course, time does not permit. I shall ask your indulgence, however, to briefly touch upon our professional responsibility and in so doing should like to tell you of three friends of mine. These friends undoubtedly can be patterned after like friends of yours. The first is a fine gentleman, who through the actual sweat of his brow and many hardships completed his education, having first received his B.A., then his Masters, and finally his Ph.D., after which he was besieged with many lucrative offers which he declined, choosing to return to his Alma Mater to teach, later to become the school's president. He has dedicated his life to the preparation, by his forbearance, of the education of our younger people.

The second friend—a young man who was fortunate in that his parents could well afford an excellent medical education. Of this he took full advantage and because of his earnestness and desire, he became an outstanding man in his field; having just completed a book on a special surgical technique which is now being reprinted in two foreign languages. Yet, in all his success and progress he never neglected to give of his time and talents to the free clinics and took his turn in teaching in the hospitals and medical school with which he was connected. All this gratis.

MARVIN D. MARR

Cedar Rapids, Iowa

Assumes Office of President

AMERICAN PODIATRY ASSOCIATION

(National Association of Chiropodists)

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The third friend—a gentleman with no education who started keeping himself alive as a child by shining shoes on the street corners. Eventually, with his determination and personality, gaining enough in worldly goods to open a shoeshine parlor of his own. As time went on he enlarged and hired other young men, the only qualification being that they were honest and would go to school. Time passed and this friend, through frugalness and savings, purchased more and more property until today he has an extensive supplementary income. He has provided many boys with jobs so that they might get a higher education and no one will ever know how many lads he has actually put through school.

My point in telling you about these three friends is obvious—where else but in the great country of America could this be done? Done on the basis of individual freedom and initiative and the fundamental right of one to choose his own career and livelihood—this is the very thing that has helped to make America what it is —this has taught us to respect the rights of others—has taught us the four freedoms —has taught us to cherish personal rights and States' rights.

It is by these standards that every profession including medicine, education and shoe shining, and all others, has grown, and in one form or another through study and research has been able to do more for mankind. It is by these standards that the profession of Podiatry has reached its present status and takes its place on the health team of the Nation.

It is because of these standards and rights that we know and cherish, that you and I, as individuals, must not take for granted the conditions that may exist in our own States and communities. We must be ever alert to offer our services to and through the various agencies of our communities and our States. The agencies and people whom they serve will welcome your association and assistance.

It is only by our individual activities where we know and reside that we can "lift the bushel basket so that our light may shine." It is only by our willingness to serve and pay community rent that we can rightfully preserve our way of life and prevent the octopus of socialism in one form or another from stifling us.

There are many health problems such as that involving the mentally disturbed, our youth, and our aging which are local and State problems and which should remain local and State problems and be solved and rectified by the people, the insurance industry, the social agencies, and the allied health groups of that community and State. It is necessary for all such groups to lend their time and talent towards solutions of these problems—it should not be a federal responsibility fraught with politics or political intervention. Your responsibility and mine is to offer immediately our services towards the solution of these problems. We cannot afford selfishness and self-indulgence—we must further dedicate ourselves to professional responsibility and community assistance.

Your national organization cannot accept this responsibility for you or me, but can only lend a hand in its role as a service organization created for your benefit and mine and for the better foot health of the Nation. Yes, the APA through its officers and committees, can meet with national organizations of allied medical peoples.

It can meet with Federal agencies.

It can meet with your Senators and Congressmen.

It can meet with public relations experts.

It can meet with national insurance industry officials.

It can meet with officers and officials of labor organizations.

It can disseminate information about your activities and accomplishments to the public at large.

It can stimulate research on a national level.

It can meet with and encourage our own educational institutions, make every effort to increase student enrollment and promote their financial stability.

All of these your Association can do, is doing and will continue to do. This is your service organization, designed to be your spokesman at the national level, and designed to provide the necessary tools with which you and I, through our state and regional and local groups, can better accomplish the tasks that only you and I as individuals can fully accomplish.

In the coming year your councils, your committees and your officers will be at work planning and preparing more of the tools to help us pay our "community rent." They will represent us at national levels in as many places and ways as they can. They will be hard at work helping our educational institutions. They will be serving you, your needs, your hopes and your aspirations, because the unique foot care service we offer has great medical, social and economic significance not only for our own patients but also the general public.

Each of us in some measure, large or small, has contributed toward the greater progress of our profession, thus creating better foot care for the "foot weary" of our nation. Let us humbly, yet with a true sense of pride in our profession, assist in raising that "basket so that the light may shine" on a local level. Let us remind ourselves again and again that we cannot buy or promote prestige and recognition—it must be proven, earned, and deserved.

I humbly beg your indulgence and your prayers that your officers and trustees shall be able to forthrightly represent you for the coming year.

MARVIN D. MARR, D.S.C.

PRELIMINARY REPORT

1960 Annual Meeting

The forty-eighth annual meeting of the Association began with the forty-first annual session of the House of Delegates on August 25, 1960, at the Drake Hotel, Chicago, Illinois. The Board of Trustees, the Council on Education, and some special and reference committees met earlier in the week. The Scientific Sessions began with "Geriatrics and the Health Professions" on Saturday, August 27th, and extended through August 30th with over 100 participants. Breakfast Sessions were a highly successful innovation.

Marvin D. Marr was honored at his Inaugural Banquet, Monday, August 29th, and delivered his inaugural address.

Outgoing President, Marvin W. Shapiro, was honored at the President's Reception and Ball Sunday evening, August 28th. A surprise honor was bestowed upon him by his induction as Chief Theis-We-Sway-He of the Otoe Indian Tribe, arranged for by the State Societies comprising Region II (Southwest).

Robert Shor, Los Angeles, California, was elected President-Elect; Benjamin C. Mullens, Binghamton, New York, 1st Vice President, and Joy E. Adams, St. Petersburg, Florida, 2nd Vice President. Ralph E. Owens, Oklahoma City, Oklahoma, and Earl G. Kaplan, Detroit, Michigan, were returned for three-year terms to the Board of Trustees and James A. Conforti, Bedford, Ohio, was elected to fill the one-year unexpired term created by the election of Joy E. Adams as 2nd Vice President. Philip R. Brachman, Chicago, Illinois, was re-elected and Max Pomerantz, M.D., Cleveland, Ohio, was approved

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for three-year terms to the Council on Education. Leo N. Liss, San Francisco, California, and Jonas C. Morris, Audubon, New Jersey, were re-elected respectively, Speaker and Vice-Speaker of the House of Delegates. Joseph Guy, Quincy, Massachusetts, was elected and Lester A. Walsh re-elected to the Board of Trustees, American Foot Health Foundation. Milton Wolfson, New York, New York, Merton L. Root, San Jose, California, and Seymour H. Jacobson, New Haven, Connecticut, were elected respectively for three-, two- and one-year terms to the Board of Trustees of the Fund for the Advancement of Podiatry (Chiropody) Education.

A very important decision of the House of Delegates was to authorize for the enlargement of Headquarters Staff with additional personnel, appropriating some additional funds, temporarily, from the general reserves if necessary. This is for the explicit purpose of accelerating the following of immediate priorities in the overall A.P.A. program: 1) Improvement of faculties and physical facilities of our schools by obtaining increased financial support and motivating more qualified students to enter the profession through our expanded Student Selection program. 2) Informing the public of the importance of good foot health to total foot health and stressing particularly the value of foot care to the worker and his family. 3) Seeking proper coverage in health insurance contracts for podiatry-chiropody patients.

John Hinman, M.D., Secretary of the American Medical Association Committee on the Relationship of Medicine to the Allied Health Professions, addressed the House of Delegates on his committee's work. The House also heard from Mr. Julius F. Rothman, Staff Representative, AFL-CIO Community Service Activities, on Community Service Programs and Participation.

The State Officer's Conference this year was very well attended and program materials were presented and discussed in the areas of Hospital and Medical Relations, Labor Health, Health Insurance, Public Education and Information and State Practice Acts.

The following 1960 Stickel Annual Awards for Research in Podiatry (Chiropody) were made: Gold Medal (1st Place), "Total Contact Restoration Prosthesis for Partial Foot Amputations" by Sherwin E. Levy, Los Angeles, California; Silver Medal (2nd Place), "Griseofulvin and Tinea Pedis" by Morton H. Walker, Stamford, Connecticut; Silver Medal (3rd Place), "Induced Postural Changes Resulting from Orthopedic Programming" by W. A. Pepin, San Diego, California; Bronze Medal (4th Place), "The Chirometer" by H. H. DiPiero, Youngstown, Ohio, "Twenty-Two Years of Podogeriatrics" by Leo N. Liss of San Francisco, California, and "Varicose Veins. . . . A Functional Disorder of Leg Musculature" by Leonard L. Lewis, New Brunswick, New Jersey (these papers tied for 4th place); Honorable Mention, "Retarded Osseous Development as a Primary Factor in Weakfoot" by Joseph R. Cinzio, Passaic, New Jersey, and "An Original Device for the Prevention of Leg Congestion" by Milton D. Roven of Brooklyn, New York.

The following medals were awarded to Scientific Exhibits: 1. Individual—Class A (supported by grants-in-aid), Gold—Raymond K. Locke, Englewood, New Jersey, "Griseofulvin Therapy in Fungus Infections of the Foot"; Sterling—Morton H. Walker of Stamford, Connecticut, "Therapeutics of Chymar Ointment"; Bronze—Alan N. Davis of Snyder, New York, "Hyperidrosis—The Common Denominator in Foot Disease"; Honorable Mention—Milton E. Ashur, Jersey City, New Jersey, "Griseofulvin in Treatment of Tinea Pedis and Onychomycosis"; Class B (unsupported), Gold—E. D. Peterson, Chicago, Illinois, "Bone Pathology"; Sterling—Milton R. Lewis of Chicago, Illinois, "The Diabetic Foot"; Bronze—A.P.A. Students Association. 2. Public Education and Information, Gold—A.M.A. Exhibit on Aging; Sterling—A.P.A. Audio-Visual Council; Bronze—Podiatry in the U. S. Army. 3. Institution-sponsored (schools, hospitals, specialty groups), Gold—George R. Gabriel and Emil Burger, Chicago, Illinois, "Gerontal Pathological Fractures"; Sterling—Earl Kaplan of Detroit, Michigan, "Surgical Exhibit by Civic Hospital; Bronze—Sherwin E. Levy, Los Angeles, California, and Wright, M.D., "The Use of a New Emollient in Cutaneous Disturbances of the Foot"; Honorable Mention—"Alpha Gamma Kappa—National Scientific Series" by Paul J. Peters, Cleveland, Ohio. 4. High School Science Fair and Foot Health Exhibits—Gold—Junior Division, Dennis Ryan; Gold—Senior Division, Joel Feder and Sterling—Senior Division, Marvin Raidbard.

It is estimated that more than 2000 persons attended the sessions, meetings and exhibits. A preliminary count indicates that 622 podiatrists-chiropodists, 191 members of related professions and associations, and 214 technical exhibitors and advertising representatives were registered. There were 92 exhibits displayed—65 in the Technical Exhibits Section and 27 Scientific Exhibits in the Hall of Science. Over 500 wives, husbands, children and friends of members were present. The Second Annual Association Golf Tournament, which attracted over 50 contestants in the men and ladies divisions, will be fully reported in a subsequent issue.

POLITICAL ACTION BY PODIATRISTS

A Guest Editorial

Whenever we podiatrists exhibit an interest in proposed legislation, we are usually told that "most legislators have never heard of podiatry" or some words to this effect. This is a deplorable state of affairs and indicates that we have failed to adequately inform this very important segment of the public. Also there exists either a political apathy or a fear that political activity can in some way hurt us.

If it is apathy, it is high time we grow up enough to realize that the free exercise of the franchise is the birthright of podiatrists just as much as it is of any citizen over the age of 21. And along with the right to exercise this privilege goes our DUTY to work for election of the candidate of our choice. It is not enough merely to go to the polls. If we believe enough in a candidate to vote for him then we must believe in him enough to help him in his campaign. This help does not necessarily mean financial help. We can merely express our reasons why we support our man whenever the opportunity presents itself. One need not be argumentative. Enumerating a man's virtues is no cause for antagonism and certainly will not cause you to "lose a patient." Other methods of helping may range from sending postcards or distributing campaign literature to the contributing of money to the campaign itself. Whatever is done is done in the true spirit of helping the candidate without expecting anything in return. After the candidate wins he'll be well aware of the help whenever asked to consider worthwhile legislation we are interested in, whether it has to do with podiatry or not.

If your reason for political inactivity is fear of reprisal, it is time you took a long look at the facts. Haven't you noticed that one of Kennedy's most outspoken opponents is now his running mate? And didn't you notice that Nixon's most eloquent critic finally introduced him to the Convention and pledged his support to him? Do not fear reprisals. No politician wants to hurt the opposition. On the contrary, he will do everything in his power to win the opposition to his side. No group of people on earth is more sensitive to the voice of the people than the politician. They respect and admire an individual or a group for the courage to stand up for their convictions.

The American Podiatry Association or its component societies cannot take part in political campaigns nor should they sanction any political activity, but also there is no attempt to hinder a member or group of members from engaging in such activity, in fact they should encourage it.

Therefore, study the records of the candidates and the parties involved, make your selection, and go to work. By joining a Podiatrists for Nixon Committee or a Podiatrists for Kennedy Committee, you will help to serve notice on both parties that podiatrists are an active force in the community. Above all, learn *why* you support the man of your choice (from President to the local official) and then stand up and say so whenever the opportunity presents itself. If possible, get to meet your candidate or write to him (or her) personally. Get your efforts on the record as part of some organized support. Your elected candidate will be pleased to know how you have supported him whenever you call on him to consider your point of view.

ROBERT L. JACOBY, D.S.C.
Berkeley, California

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TAX CLINIC

HENRY KENT, C.P.A.
New York, N. Y.

Mr. Kent will conduct a regular column on tax problems for the podiatrist-chiropodist. Your questions may provide the basis for future columns.

SELF-EMPLOYED INDIVIDUALS RETIREMENT BILL

One of the "hottest" pieces of tax legislation to come along in some time is H.R. 10, the "Self-Employed Individuals Retirement Bill." For a number of years, this bill has been in the committee rooms of Congress under the various names of its many sponsors (perhaps one pair of legislators who introduced the legislation — Jenkins-Keogh rings a familiar sound) only to find itself not acted upon at the close of session. The bill primarily intends to provide the establishment of a pension fund for self-employed individuals by permitting such an individual to deduct from his taxable income the premiums paid (up to $2,500 per year) to such a retirement fund. Up to now, it was the opposition of the U. S. Treasury which has defeated the bill in committee. The House passed the bill last year and the bill is now being considered by the Senate Finance Committee. That in itself would hardly give rise to hope for making the bill into law. However, the U. S. Treasury has finally made a counterproposal and the chances for passage have now come closer to reality.

Under the Treasury plan, self-employed individuals (including partners) would be allowed to obtain retirement benefits only by also establishing a qualified pension plan, i.e., meeting the present requirements of the Internal Revenue Code as to nondiscrimination of benefits and coverage for their own employees. In addition, certain other provisions have to be met. Some of these are listed below:

(1) A proprietor would be allowed to be covered under the plan only if he performed personal services. Since the objective of such pension plans is to provide retirement benefits, it would at least, in the opinion of the U. S. Treasury, be entirely inappropriate to allow inactive owners who derive their income entirely from investments to participate. Basically speaking, this is only a logical extension of the law presently in existence which permits the coverage of corporate employees in a qualified pension plan, but excludes shareholders in a corporation who are not employees of the corporation. Since most professional self-employed individuals derive their income from personal services, this limitation does not represent a bar to participation in the retirement plan.

(2) Limitations would have to be placed on pension contributions. A suggested basic annual contribution for self-employed individuals would be permitted, amounting to 10% of his earned income (earned professional income—excluding dividends, interests, etc.) or $2,500, whichever was less. Such contributions, however, could not be discriminating in favor of the proprietor as compared with employees. This requires that a self-employed individual who also has employees must cover such employees at the same percentage rate as he covers himself.

Plans could not be terminated at will since such termination could lead to special tax advantages. Taxpayers could reduce their taxes in high income years by reasons of their contribution and withdraw the funds from the plan in low tax years.

This unintended tax benefit could be avoided by requiring that the plan be irrevocable and by imposing penalties on any withdrawals other than for disability before some normal retirement age, say 60 years. Such penalties could include an increased tax on such early withdrawals and a denial of the opportunity to participate in a qualified plan for five years. There would also be included a requirement that the self-employed individual start withdrawal before some maximum age, such as 70 years.

A maximum amount of contributions to the retirement fund is also contemplated —namely $50,000.00 for each taxpayer (20 years at $2,500.00 per year).

If the bill should become law in its present outline, a self-employed individual could deduct the premiums paid to a qualified retirement plan (subject to limitations) from his taxable income. It is contemplated that insurance companies and/or certain banks will adminster the plan. Upon retirement, the taxpayer will, of course, be taxed on the benefits as they are paid to him. Since most taxpayers are in a higher tax bracket during their working years, they will obtain a tax deduction for their premium payments at a higher rate than taxed upon receipt of the retirement benefits. So, there is a distinct tax advantage to most professional men to participate in such a retirement fund.

As this article goes to press, the fate of the bill may be decided. If it should become law, a reappraisal of your insurance and tax situation would be desirable. Professional advice should be obtained on the exact final wording of the law and its applicability to your tax situation.

BOOK REVIEWS

COLOR ATLAS AND MANAGEMENT OF VASCULAR DISEASE

William T. Foley, M.D., F.A.C.P., and Irving S. Wright, M.D., F.A.C.P., $18.00, 170 pp. including index, 134 color slides, 28 x-ray films, 5 black and white photographs, 10 tissue slides, Appleton-Century-Crofts, Inc., 35 West 32nd Street, New York City, 1959.

Dr. W. T. Foley is Associate Professor of Clinical Medicine, Cornell University Medical College; Associate Attending Physician and Chief of the Vascular Clinic, the New York Hospital. Dr. I. S. Wright is Professor of Clinical Medicine, Cornell University Hospital, Attending Physician of the New York Hospital.

"Color Atlas and Management of Vascular Disease" gives you remarkably perceptive advice on providing adequate care at the proper time for the patient suffering from vascular disorders in the lower extremities. It is decidedly different from the usual textbook in its approach. This book is a practical, straight-forward presentation of the diagnostic characteristics of many and varied vascular disorders. The illustrations showing the characteristic diagnostic changes – in color, with drawings, x-rays, tissue slides, black and white photographs– comprise a virtual atlas of circulatory conditions and their treatment.

The book is based on the authors' 15 years of experience in the management of vascular diseases. In addition to commonsense advice on management, the authors suggest a conservative, rather than surgical, method of treatment in these disorders. The various disorders are presented in the same manner patients present them to you in the office. The numerous factors responsible for symptoms of different circulatory conditions are presented in such a way that it enables the podiatrist to understand the cause, rate of progression, and probable outcome of the disease. By un-

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derstanding the evolution and development of vascular disease, intelligent management is more easily established. Case histories and color slides are demonstrated wherever they can be enlightening. Diagnosis is covered in clear-cut clinical pictures that include etiology, physiology, pathology, signs and symptoms and the individual characteristics of varied vascular disorders. Of particular interest to the podiatrist is the treatment of intermittent claudication in the extremities by walking exercises and the use of elastic support and postural treatment of lymphedema. In addition to the common-sense advice on the management of vascular disorders, the authors describe the more formalized methods of diagnosis and treatment for such conditions as: arterial diseases, venous diseases, lymphedema, vasospasm, primary Raynaud's disease, acrocyanosis, livedo reticularis, frostbite, pernio, scleroderma, thromboangiitis obliterans, atherosclerosis obliterans, neurovascular syndromes of the shoulder girdle, thrombophlebitis, phlebitis with gangrene, phlebitis secondary to vasospasm, peripheral neuritis, ergot poisoning, cryoglobuminemia, causalgia, Sudeck's atrophy, rheumatoid arthritis and the other collagen diseases, periarteritis nodosa, aneurysm (arteriovenous anastomosis-fistula), diseases of the small vessels and blood vessel tumors.

The problems inherent in diagnostic vascular disease are both basically simple and vastly complex. Again, this text is by no means an attempt to cover exhaustively this or any other aspect of the over-all problem. It is, rather, a drastic simplification of the subject, relying purely on fundamentals which have proved themselves by extensive clinical application, to more adequately serve its intended purpose as a guide and general reference. The bibliography, index, list of cases and illustrations, diagrams and color photographs are excellent.

Jack Ranzer, Pod.D.

DRUGS OF CHOICE

Walter Modell, M. D., *Editor*; Director, Clinical Pharmacology and Associate Professor of Pharmacology, Cornell University Medical College; Attending Physician, New York Veterans Administration Hospital; Associate Visiting Physician Bellevue Hospital; Member, Poison Control Advisory Board of New York City; Member of Revision Committee, U.S.P. XVI; Editor, Clinical Pharmacology and Therapeutics. Price $13.50, 42 chapters, 913 pages plus 43 pages of index, with special Drug Index on pages 813 through 913. This special Drug Index names the drug and its manufacturer plus the Generic name. This index alone makes the book a valuable reference publication. Published by The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Missouri, 1960-61.

This book tells you how to select the best drug and the principles of the choice of drugs. It covers the physical and chemical considerations of the choice of medications.

Covered comprehensively are the choice of drugs for children and such items as agents to adjust and maintain internal homeostasis, the choice of diuretics, the choice of drugs for nutritional disorders, the choice of local antiseptics, choice of antibacterial agent, drugs for viral infections, drugs for stimulation of mental and physical activity, and the choice of proper drugs for relief of pain, to name a few items.

In this reviewer's opinion, the chapter on the choice of an anesthetic should prove of the greatest interest to chiropody-podiatry, as are the informative chapters on sedatives, tranquilizers, hypnotics and antibacterial agents.

The reviewer finds this a most interesting and informative reference book and recommends it to every practitioner as a must in his reference library. Summing up, this book is informative, educational and very easy to read and understand.

Harry L. Hoffman, Ph.G., D.S.C.

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

HARRY L. HOFFMAN, Ph.G., D.S.C.
Chairman, Council on Podiatry Therapeutics and Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This is a regular monthly column prepared from information furnished by the pharmaceutical house. We invite questions, which we shall endeavor to answer, or obtain the answer.

Decagesic

Anti - inflammatory steroid - analgesic-antacid combination; antirheumatic therapy; dexamethasone preparation.

Description: Each peach-colored, scored, capsule-shaped tablet contains: Dexamethasone 0.25 mg., Acetylsalicylic acid 500 mg. and Aluminum hydroxide (dried gel) 75 mg.

Action and Uses: For relief of pain associated with mild and moderate rheumatoid arthritis, the systemic manifestations of collagen diseases and musculoskeletal conditions such as bursitis, acute and chronic pain (low back).

Administration: Orally as needed.

Caution: Precautions attendant on steroid therapy must be observed.

Supply: Decagesic – in tablets, bottles of 100 and 1000. By Merck Sharp & Dohme, 640 N. Broad St., Philadelphia 1, Pa.

Acrosurgic Sterile Topical Spray Powder

Description: An aerosol dispenser contains 710 mg. of sterile tetracycline HCL in powder form with chlorinated-fluorinated hydrocarbons as propellant.

Action and Uses: Achromycin, brand of tetracycline HCL is provided in spray powder form for use as a nonirritating topical antibiotic in the prophylaxis and treatment of cutaneous infections caused by tetracycline-sensitive organisms.

Administration: Topically over affected area as thin layer of powder.

Supply: Achrosurgic Sterile Topical Spray Powder—Aerosol dispenser, 3 oz. By American Cyanamid Co., Surgical Products Division, 30 Rockefeller Plaza, New York 20, N. Y.

Librium

Psychopharmacologic agent; tranquilizer

Generic Name: Methaminodiazepoxide

Description: Each green and black capsule contains 10 mg. of Librium, brand of methaminodiazepoxide.

Action and Uses: This is a new tranquilizing agent reported to control without impairing mental acuity or dulling the personality. In certain patients, it also exerts an anti-depressant effect. For use in all degrees of anxiety and tension, tension headache, pre- and post-operative apprehension, premenstrual tension, chronic alcoholism, agitated depression, ambulatory psychoneuroses (e.g., acute and chronic anxiety states, phobias), obsessive-compulsive reactions and schizoid behavior disorders), and acute agitation (delirium tremens, hysterical and panic states or acute stages of schizophrenia, and paranoid states).

Administration: Orally. The dosage should be individualized according to diagnosis and response. The usual adult dose in common emotional disturbances is 10 mg. 3 or 4 times daily. In severe psychoneuroses, dosage may be doubled. In geriatric patients and children, dosage should be limited initially to 10 mg. once daily, to be increased as needed and tolerated.

Caution: Mild sedation and ataxia are indications of overdosage and disappear promptly upon reduction of dosage or discontinuation of therapy.

Supply: Librium—capsules in bottles of 50 and 500. By Roche Laboratories, Division of Hoffman-LaRoche Inc., Nutley 10, N. J.

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Carbocaine Hcl.

Description: Carbocaine is a potent new local anesthetic, clinically effective in low concentration and can be used safely for many types of local anesthetic procedures ranging from infiltrations to regional block and including caudal and peridural technics. Because of rapid onset, adequate depth and long duration of anesthesia, combined with excellent tissue compatibility, this new agent represents a new and marked advance in anesthesiology. This preparation is extremely stable and solutions can be autoclaved repeatedly and/or stored for long periods without risk of decomposition.

Advantages: Carbocaine may be used with epinephrine but has the advantage of a highly satisfactory performance without it. The drowsiness or lassitude observed sometimes with local anesthetics has not been observed with Carbocaine.

Extensive pharmacologic and clinical studies on Carbocaine have been carried out in the past 3 years in the U. S., Sweden, Denmark, Germany and other countries. Luduena, Hoppe, Coulston and Drobeck have recently reported on its pharmacology and toxicology. Clinical trials by many investigators in this country and abroad have established the wide usefulness and exceptional safety of Carbocaine.

Administration and Dosage: As with other local anesthetics, the dosage of Carbocaine varies considerably and depends on the surgical procedure, body area, individual response and anesthetic technic. The smallest dose needed to produce the desired results should be administered. According to our available information, Carbocaine generally will produce complete and effective anesthesia for patients undergoing major and minor surgery, and for therapeutic purposes, in dosages that are more than half those needed when procaine hcl. is used. If epinephrine hcl. is added, a 1:200,000 concentration is preferred. Carbocaine solutions in which epinephrine has been added should be used cautiously in elderly patients or in those with hypertension, cardiovascular disease, diabetes or hyperthyroidism. Caution should also be used and exercised in using anesthetic solutions containing epinephrine in such areas as the ears, fingers, toes to avoid prolonged vasoconstriction and ischemia.

The following dosages will prove satisfactory: For nerve block, from 5 to 20 cc. of a 1 or 2% solution depending on the area and extent of block; for infiltration, 1% solution highly satisfactory; for therapeutic block (in management of pain), from 1 to 5 cc. of a 1% or 2% solution, (Carbocaine Hcl. solution may be diluted with Sodium Chloride injection U.S.P., sterile saline solution).

Supply: 1% in sterile saline solution in multiple dose vials of 50 cc. Also in 2% solutions in multiple dose vials of 50 cc. vials. By Winthrop Laboratories, 1450 Broadway, New York 18, N. Y.

Turgasept

Ionic Deodorizer Aerosol

Introducing a new concept in malodor control for use by the Medical Profession, Hospitals and Podiatry offices. This provides odor correction without Formalin, Phenolic Resins or Floral Masking. Odors are neutralized immediately and for prolonged periods, without masking or substituting a new odor and without causing nasal anesthesia. Turgasept dissipates undesirable odors. This preparation removes organic as well as inorganic odors in the air. In addition, it removes odors that linger about objects in the room. A single application sprayed against the baseboard of a room can nullify odors.

Caution: Keep spray away from plastics and varnished surfaces.

Supply: Aerosol Spray in 16 oz. hospital and office size Aerosol Can. Also available in concentrate form. Obtainable only through wholesaler-dealer or your supply house or your pharmacist. By Turgasept Co., 100 Varick Street, New York 13, N. Y.

PODIATRY-CHIROPODY ABSTRACTS

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Editors of Local, State and Regional Publications are requested to provide copies to Dr. Shapiro who is editing this section of the Journal.

X-RAY DIAGNOSIS OF FOOT DISORDERS

E. E. Sheldon, M.D., The American Podiatrist, Vol. 15, No. 2, March 1960.

The author has limited his discussion to the difficulties and pitfalls encountered in the X-ray diagnosis of pes planus, pes cavus, osteoporosis and exostosis.

In regard to the diagnosis of pes planus it is stressed that the X-ray examination should be made with the patient standing on one foot to produce a full weightbearing position. This will necessitate a short exposure time to prevent motion. For diagnosis of pes cavus lateral exposures are imperative. X-ray diagnosis for osteoporosis can be made only by the following: (1) systematic follow-up X-ray examinations for a few months, (2) comparative X-ray studies of both lower extremities, and (3) studies under identical standardized conditions, as to voltage, milliamperage, exposure time and development. The author goes on to state that the main reason for failure in the diagnosis of exostosis is inadequate number of positions taken and improper timing, for in the early stages an exostosis may be entirely cartilaginous, therefore invisible on X-ray.

ONE HUNDRED VERRUCAE: AN UNUSUAL CASE REPORT

Allen Fiegenbaum, Pod.D., The American Podiatrist, Vol. 15, No. 2, March 1960.

The patient presented himself with multiple verruca on the plantar surfaces of both feet, which had been present two years. The lesions had been increasing in number and upon examination approximately 100 were counted.

Treatment consisted of weekly applications of salicylic acid ointment and vitamin A orally, 100,000 units daily, with poor results after a period of 3½ months. At this point the patient had to report for military maneuvers and was instructed to do nothing for his condition other than to continue vitamin A therapy as directed. During the two-week period all lesions resolved. The author concludes that the blood level of vitamin A over the four-month period could have been a factor in the resolution of the lesions along with the psychological stimulus of a sudden change in environment.

REPORT ON A CLINICAL TEST OF BOROTANNIC COMPLEX IN THE TREATMENT OF TINIA PEDIS

Franklin Charlesworth, F.Ch.S., The British Chiropody Journal, Vol. 25, No. 2, Feb. 1960.

The author reports on a case study of 36 children with diagnosed tinea pedis and 5 with interdigital maceration. Daily applications of borotannic complex were employed with excellent results reported. Of the 36 cases of tinea pedis treated, only 3 were inconclusive. Of the 33 successfully treated cases, many required no more than 6 daily applications. Others needed 12 or 14 applications. None required treatment exceeding three weeks. In the group with interdigital maceration all areas cleared following three daily applications. The author describes the action of the medication as follows: the solvent evaporates leaving the borotannic residue on the skin which is dissolved due to the skin moisture creating an acidic medium. In addition the proteins of the fungi are coagulated

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and the skin is "tanned." This tanning action inhibits the formation of moisture and in doing so de-activates itself. As new moisture forms in the skin, the mode of action is repeated and acyclic and continuous fungicidal and fungistatic effect is obtained.

KERATINIZATION—THE BIOCHEMISTRY OF CORN AND CALLOUS FORMATION

Peter J. Read, F.Ch.S., The Chiropodist, Vol. 14, No. 12, Dec. 1959.

The old theory of corn and callous formation based upon a localized hyperemia due to trauma and the resultant overproduction of stratum germinativum cells is refuted by the author. Given that the supply of nutriments is sufficient for a normal rate of reproduction, the rate of cell production in the skin is independent of the blood supply. The callosities form, not because of increased cell production, but rather because of a decrease in the normal shedding process of the outer layers of the skin. The current views on the biochemistry of keratinization are gone into quite thoroughly. The horny layer of the skin consists of keratin (which is a fibrous protein) bound up with fats and water. It is the fat and water which maintain the elasticity of the horny layer, for they act as "intramolecular lubricants." The fatty lipids in the skin aid in the water-retaining power of the skin and it is the water which prevents the skin from becoming brittle.

The author goes on to state that corn and callous formation is a disorder of the desquamation process of the skin due to irritation and a change in the character of the keratin to make it more closely resemble the keratin found in nails and hair, for here, too, the keratin does not shed.

The surface keratin in certain areas is more likely to react in this way. The area of the horny layer of the skin around the pores is particularly sensitive and this may account for "seed corn" formation.

The importance of this thesis is that it brings one step closer a solution for the corn. The answer to the problem probably lies in an agent which will modify the keratinization process.

SQUAMOUS CELL CARCINOMA OF THE GREAT TOE—A Case Report

Jack Stern, D.S.C., Canadian Podiatry Journal, Vol. 16, No. 1, Jan. 1960.

The patient presented himself with what appeared to be a suppurative onychocryptosis of the great toe, left foot, with exuberant granulation tissue and marked edema. There was also present a mild cellulitis. A history revealed two years' treatment including complete avulsion of the nail with no improvement of the condition. The author's initial treatment included a complete blood count and urine analysis and excision of the proud flesh. In six weeks' time the proud flesh recurred. Lab reports were negative.

Surgery was then instituted including wide excision of all necrotic tissue to permit good coaptation of healthy tissue. A Winograd procedure of the nail was performed at the same time and the tissue was biopsied.

Lab report of the tissue was squamous cell carcinoma of the skin—Broder's Grade III. X-ray therapy was then instituted and examination two years later revealed no recurrence and no evidence of metastasis elsewhere on the body.

"The leader's duty, ordained by his nature, is to be bold, unflinching and fearless."

The Song of God
—Bhagavad—Gita

DIGESTS FROM THE LITERATURE

Anyone wishing to read the complete article, if not available in your local library, may borrow it through interlibrary loan. A microfilm may be borrowed from the National Medical Library, Washington 25, D. C., or a photo-duplication may be obtained from that library.

CIRCULATORY SYSTEM

Differential Diagnosis of Leg Ulcers, Anning, S. T., Brit. J. Clin. Path. 13: 95-105, 1959.

The rational therapy of the numerous types of leg ulcers is dependent upon their differential diagnosis.

Circulatory ulcers are arterial or arteriolar in type. Arteriosclerotic ulcers affecting large and medium sized arteries are most common in patients over 60 years old. Slow occlusion of the arteries by plaques of atheroma may gradually cause a thrombosis or a sudden blockage of the vessel. Impairment of blood supply can lead to gangrene of the toes. As deep tissues become necrotic, a sloughing ulcer penetrates the deep fascia. Peripheral pulses are diminished, the foot is cold and discolored and there may be radiologic evidence of arterial calcification. Hypertensive ulcers, common in women 35 to 40 years old, are very painful and heal slowly. Hypertrophy and degeneration of the muscle of the media and internal lamina occurs and a slight trauma can cause thrombosis in the arterioles of the skin, leading to necrosis and a shallow ulcer.

Erythrocyanosis, the result of slowing of arteriolar blood flow can cause an ulcer. Slowing may be constitutional or familial. It produces narrowing of the arterioles and vasospasm, or it can follow a neurologic disease. Perniosis may improve with maturity, unless due to poliomyelitis, in which case the skin is discolored from the knee down. The dark patches containing nodules break down, causing indolent ulcers. Sympathectomy may bring temporary relief. Subcutaneous nodules lead to superficial extension of the inflammatory necrotic process, producing a slow-healing, "punched-out" ulcer, in cases of allergic reactions in perniotic legs. These allergies may be due to micro-organisms, drugs, tubercle bacilli carried by the blood stream (but not giving a positive test), or they may be caused by nodular vascularities in middle-aged women. Syphilitic ulcer occurs in middle-life, usually in the upper two thirds of the leg. Gummatous ulcers on the lower third of the leg are difficult to diagnose, but give a positive Wasserman test. Tertiary ulcers respond quickly to penicillin therapy, or potassium iodide and mercury. A varicose or postphlebitic ulcer in a syphilitic patient is not affected by this treatment.

Venous ulcers, post-thrombotic (70 per cent) or varicose, result from lack of muscular contraction, incompetent deep venous valves, or venous thrombosis. Chronic edema, pigmentation, indurated plaques and ulceration occur on the lower leg, but not on the foot. Venous ulcers on the lower third of the medial aspect of the leg, preceded by tiny superficial veins in the skin near the malleoli (ankle blow-out syndrome), probably result from valvular incompetence and increased pressure in the veins of the ankle. Multiple, small, intensely painful venous ulcers may develop near the malleoli, or enormous offensive ulcers may encircle the lower part of the leg. All are attended by chronic edema, pigmentation and areas of induration.

Less common types of ulcers are: (1) *traumatic* ulcers, due to frequent injuries; healing is delayed by constant movements of the leg, secondary infection, and strain on the circulation. (2) *Infective* ulcers—

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pyogenic, tuberculous, desert sore and oriental sore. (3) *Tropical* ulcers are caused by infective organisms and malnutrition.

Ulcers of the leg are often associated with systemic diseases. Arthritis of the knees and legs can cause reduced efficiency of the muscles of the leg and impair venous circulation, or arthritis can produce ulcers of the ankle when knees are not affected. Rarely, ulcerative colitis causes leg ulcers —probably the result of hypogammaglobulinemia. Many blood diseases are associated with leg ulcers. Bone diseases can be attended by ulcers of the leg and neurologic diseases can cause trophic ulcers on the sole or legs. Paraplegia may be accompanied by shallow ulcers over the malleoli. Ulcers of the leg are seen in Reynaud's disease.

Neoplastic ulcers, very rare and often overlooked, may be warty or psoriasiform and require special therapy. Signs of venous insufficiency are absent. The margin is raised, irregular and infiltrated; diagnosis is confirmed by biopsy.

The Treatment of Primary Varicose Veins, Harridge, W. H., Surg. Clin. North America 40: 191-202, 1960.

Primary varicosities are due to congenital valvular or vein wall deficiencies. These veins and valves may be damaged by trauma, by superficial thrombophlebitis or by mechanical obstruction during pregnancy. The long or internal saphenous vein is commonly involved, the short or external saphenous vein less commonly. There may be a combined involvement of the long and/or short saphenous veins with the incompetent perforator or communicating veins. A number of tests are used to determine which system is deficient: the percussion and cough impulse used as rapid superficial methods of evaluation; the tourniquet tests such as the Brodie-Trendelenburg test with one, two or three tourniquets, and the Perthes' comparative tourniquet test. The most practical are the percussion test and the single tourniquet Brodie-Trendelenburg test.

Conservative treatment is of value for patients in whom surgery is contraindicated, in preparation for operation on patients with advanced insufficiency and edema or ulcers, and in pregnant patients. Cooperation of the patient is imperative. The foot must be kept in motion while standing, to maintain muscle-pumping action; while sitting the foot should be elevated. The patient should lie supine with the foot above the heart level three to four times daily for 15-minute periods. An elastic bandage or properly fitted elastic hose should be worn throughout the day. Any fungus present should be eliminated by proper foot care.

Stasis ulcers are preferably healed before operation for varicose veins in order to shorten hospitalization time and to reduce the incidence of postoperative wound infection. In addition to the instructions above, the patient should be told to wash the ulcer twice a day with soap and water, dry the area thoroughly, and then apply a coating of combined topical antibiotic (to reduce secondary infection) and cortisone (to prevent inflammation). The combination recommended is 1 per cent Neo-Cortof or Neo-Oxylone. Enzymatic debridement is helpful if there is necrotic tissue in the ulcer. The leg is kept wrapped from toes to knee level with rubber-enforced elastic (not cotton). A foam rubber pad placed over the ulcer under the bandage helps to compress the perforator veins. This regimen is better than use of an Unna's paste boot, if the patient cooperates.

Treatment of primary varicosities, unless contraindicated, is surgical, using saphenofemoral and/or saphenopoliteal ligation as indicated, together with complete stripping of the involved system. Incompetent perforator veins are individually ligated flush with their fascial defects. Preoperative, operative, and postoperative technics are

well described. The author does not approve of injection treatment of varicose veins. But sclerosants are helpful in obliterating residual dilated superficial veins after high pressure incompetent systems have been surgically removed. The sclerosants recommended are 1 per cent sodium tetradecyl sulfate (Sotradecol), and 5 per cent sodium psylliate with 2 per cent benzyl alcohol (Sylnasol). Elastic supports from toes to knee (including heel) are suggested for a minimum of 2 to 3 months following vein stripping, and for at least 2 weeks following periods of injection therapy.

Afflictions of the Extremities Resulting from Increased Vasomotor Activity, Beaconsfield, P., Surg. Clin. North America 40: 25-44, 1960.

To evaluate complex diseases resulting from increased vasomotor tone, it is necessary to recognize the influence of inadequate physiologic function associated with advancing years, the inherent physiologic weaknesses, and also any injuries due to cold, heat and moisture. When these factors are understood and controlled, treatment need not be symptomatic only, but directed toward prophylaxis. Disease, however caused, is always attended by a change in the vasomotor system. Peripheral vascular diseases having chronic sequelae, often are complicated not only by biochemical and hormonal influences, but also by normal aging processes. Before a patient comes to surgery, the peripheral vascular disease has probably progressed over a considerable period, and probably will continue to do so, with or without surgery. Abnormal structural changes occur only during disturbances of the dynamic functions of living cells. These disturbances, in turn, produce alteration in basic physiologic functions, before any pathologic abnormalities develop. Consideration of vasospastic disorders, therefore, must be primarily in terms of disturbed physiologic alterations, rather than in terms of a secondary pathologic process.

The physiologic abnormality attending increased vasomotor function is a narrowing of the lumen of the arterial tree; this occurs only with increase in the tone of the smooth muscular fibers. Narrowing of the blood vessels decreases the blood supply and therefore decreases the nutrients to the affected area. When cells are continually deprived of necessary nourishment, abnormal, irreversible changes can occur, initiating a pathologic process.

Direct injury can cause a break in continuity of the wall of the blood vessel and/or can cause acute vasospasm. Spasm involving the damaged arterial segment may extend to the entire vascular bed in that extremity; the causative mechanism can be neurogenic, myogenic, or both. In treatment, if sympathetic block or intra-arterial administration of papaverine or of a light anesthetic, tried first, should fail, the artery should be exposed and the segment bathed in a warm solution of 2.5 per cent papaverine sulfate. If the spasm is not relieved, the vessel may be rolled firmly between the fingers (with care not to pull on the injured arterial segment). The last resort is forcible proximal injection of saline.

Indirect injury to nonvascular tissues, producing skeletal fixation, can cause causalgia and/or post-traumatic vasomotor disorders. Necrosis may develop when spasm with ischemia is severe. If physical and occupational therapy is not curative in such cases, intravenous or intramuscular injections of Etamon 400 to 5,000 mg, or oral administration of Priscoline 25 mg., Hydergine 0.5 mg., or Dibenzyline 10 mg. several times daily may be helpful; but high doses can produce undesirable side effects. Sudeck's atrophy may be treated by slow intrafemoral injection of 10 cc. of 1 per cent procaine twice a week, until the limb is usable, when physiotherapy will be effective.

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Peripheral vasoconstriction may follow exposure to cold. With added vasospasm and decrease in blood supply, hypoxia may cause injury to the cell membrane and functional disturbance of protoplasm, eventually leading to denaturation and perhaps death. Therapy in immersion and trench foot consists of elevation of the foot (no massage or rubbing, no local application of antiseptics or ointments); protection against pressure necrosis, and prevention of secondary infection by administration of penicillin and tetanus toxoid.

The commonest causes of vasoconstriction are thrombosis and embolism. Many limbs have been saved by sympathectomy and, more recently, by arterial grafting. For the lower limbs, the treatment of choice is reconstructive surgery between the level of the profunda femoris and the distal portion of the popliteal; below this level surgery would be of little value. Arteriectomy still has a limited use, when other measures fail.

Reynaud's disease is treated by protection against cold, psychotherapy, vasodilating drugs, abstention from smoking. Livedo reticularis, another inherent condition activated by cold, produces bluish blotches mostly on the arms and legs, rarely on the hands and feet. Treatment is protection from cold; if painful and trophic changes become manifest, sympathectomy may help. Chilblains, always bilateral, cause blue-red dermatitis, edema, itching, and later chronic ulceration. Therapy consists of protection against cold and administration of ACTH and cortisone.

DRUG THERAPY

Development of Peptic Ulcer During Treatment with Corticosteroids, Aagaard, P., and Andreassen, M. Acta chir. scand. 116: 423-28, 1958-59.

ACTH, cortisone, and related steroids can give rise to ulcers or aggravate an existing ulcer. Steroids can cause ulceration in two ways: (1) They increase production of hydrochloric acid and pepsin; this may be due to a direct effect on the cells, possibly similarly to a histamine effect. (2) Steroids directly affect tissues by inhibiting fibroblast proliferation during wound healing, and by delaying formation of granulation tissue.

A study is reported of 10 patients, aged 32 to 69, 9 of whom had rheumatoid arthritis and 1 had ankylosing spondylitis, who developed ulcers following steroid therapy. Except for one patient, none had gastric symptoms before beginning steroid therapy. In 7 of the patients x-rays of the stomach in the early phase of this treatment showed normal conditions; ulceration was shown later. Hence there was no exaggeration of an existing ulcer. Two patients had X-ray examination only after onset of gastric symptoms.

Gastric resection was performed in all but one case. These patients were followed up for 2 months to 3 years; 6 were entirely well, 2 had mild gastric reactions; 1 a few months after operation seemed to have a fresh ulcer at the anastomosis. The 6 well patients were receiving steroid therapy. Patho-anatomically, the ulcers in the 10 patients differed in no way from the ordinary chronic gastric ulcers.

FUNGUS DISEASES

Griseofulvin in Treatment of Persistent Fungal Infections of the Skin, Barlow, A. J. E. Chattaway, F. W. et al. Brit. M. J. 2: 1141-43, 1959.

That griseofulvin given orally is effective in treatment of dermatophytes is a major advance in therapy. Topical treatment with fungicides has a high relapse rate. Griseofulvin is fungistatic, not fungicidal, and apparently inhibits fungal growth in its mycelial stage, with carrying away of the infection by outward growth of keratins.

Over a 7-months period 34 patients with fungal infections of the skin received oral griseofulvin, 1 to 2 g. daily. The infection

in 26 was long-standing involvement of the nails and skin by *Trichophyton rubrum* which had resisted numerous types of treatment, including avulsion of the nails. Two children with candidiasis, one man with *Trichophyton verrucosum*, and one man with tinea versicolor derived no benefit. Another man who had infection of the instep due to *Trichophyton mentagrophytes* was completely cured in four weeks. *Trichophyton rubrum* in two patients was treated with griseofulvin; both showed improvement within a few days. In one, scrapings were negative after 10 days and remained so for 6 months; in the other scrapings were still positive after 3 weeks and treatment is being continued.

Side reactions are headache, malaise, erythematous rashes and fall in absolute polymorph count; symptoms cease with discontinuance of the drug.

Treatment periods in this group of patients varied from 3 to 14 weeks. Lesions of smooth skin in most instances cleared in 10 to 14 days; palm and sole infection in 35 to 42 days; some fingernails became normal, but no toenails. Suggested factors causing variability in effects are (1) inability to absorb griseofulvin and accumulate it at the site of infection, and (2) variation in susceptibility of different strains of fungi to the drug. Until further studies are made, the therapy suggested is a combination of surgical removal of the nails, systemically administered griseofulvin and possibly subsequent use of topical fungicides.

JURISPRUDENCE

Negligence and Malpractice, Morse, H. W. G P 21: 170-72, 1960.

Three instances of suit for malpractice are briefly reviewed to show doctors how such cases arise and how they are judged. In the first case a few threads of gauze remained in the wound following appendectomy; an abscess formed which required surgical removal. The trial court took the case from the jury, stating that expert testimony had not been offered to show that leaving a bit of gauze in a wound is not in accord with the degree of skill and care common to surgical practice in that area. The United States Court of Appeals reversed this decision and remanded the case to the lower court for a new trial, stating that everyone knows that leaving nonabsorbable material in a wound is not approved surgical practice, and that it was for the jury to decide whether the abscess was caused by leaving the gauze in the wound.

In the second case, a man after injuring his back at work had suffered intense pain. The hospital surgeon diagnosed a ruptured intervertebral disk and had the patient put in traction. Earlier, the patient had informed the surgeon that he was allergic to adhesives. The surgeon applied two moleskin strips along the sides of a leg, telling the nurse to remove them if itching or burning occurred. The patient asked for their removal during the night, but she urged him to wait until morning until the surgeon arrived. However, the surgeon applied more traction to the leg and tightened the moleskin. Later that day pain in the leg became intense; the nurse tried to remove the moleskin, but became nauseated. The patient then removed it, leaving the skin looking like raw meat. When the patient left the hospital, the back pain was gone, but the skin of the leg was still raw. The leg was treated by a dermatologist for three months and became dark brown in color. Two months after returning to work, his back again became painful and the disk was removed by another surgeon. Since the patient had told the surgeon that he was allergic to adhesives, the Superior Court of the state rendered judgment for the patient. The surgeon appealed.

In the third case, a patient sued for malpractice because of pain, suffering and disfigurement caused by an incisional scar across the body, and the cost of medical

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care and medicines. While undergoing a gastroscopic examination for detection of possible cancer, following premedication to relax the muscles of the esophagus, the gastroscope during the examination encountered an obstruction at the cardia of the stomach, apparently due to spasm. The surgeon applied gentle pressure and insufflation to distend the walls of the stomach and esophagus, in order to clear a passage for the tube. Emphysema of the upper abdomen caused suspicion of possible puncture of the wall of the esophagus. The tube was removed at once. A puncture was found which required thoracostomy for removal of a rib and suture of the puncture. No evidence was offered except that of the patient and the court entered nonsuit. The patient appealed. The Supreme Court of that state sustained the decision of the lower court as the patient offered no expert testimony to prove that the surgeon had manipulated the gastroscope improperly or had done anything contrary to standard practice.

The Doctor's Day in Court, Sussman, S. T. G P 21: 178-80, 1960.

One of the most important elements for satisfactory settlement of a plaintiff's medicolegal case is a well kept record. Doctors, therefore, should be careful in reporting complaints of pain, all objective evidence of its presence, and the medications prescribed for its relief.

Before appearing in court the physician should study the case record carefully, restudy the medical aspects, peruse the literature, and instruct the attorney on the medical background if necessary. In turn he should be briefed by the lawyer on stereotyped questions to be expected. A well-prepared defense presented by an attorney with medical knowledge pertinent to the case can embarrass a physician on the other side who is poorly prepared. A general physician qualifies as a medical expert by stating his qualifications and experiences truthfully. He must be prepared to testify in detail regarding the nature and results of the initial examination of the patient. He should study the x-ray films and laboratory reports before the trial, as he may be asked to comment on them. He should state the nature of treatments given, where given, and the number of visits made.

To determine whether the disability is temporary or permanent, if possible measurements of motion and strength should be given as a fractional of the normal. (Such evaluation is well described in the J.A.M.A., Feb. 15, 1958.) Hypothetical questions should be anticipated and answers prepared by doctor and attorney. The court will refuse to accept opinions from medical literature as such testimony cannot be cross-examined. Use can be made of articles and books, however, if the attorney secures a competent medical witness who vouches for the author.

The defense counsel can cross-examine the medical witness: (1) in an effort to cast doubts on the doctor's disinterest in the suit; (2) to impugn his qualifications; (3) to minimize the importance of the injury received and/or its permanence. The first two technics are unimportant if the physician carefully states his qualifications and experience, and avoids agreements partly or wholly contingent upon recovery.

Compensation paid a medical witness is for time expended, not for his testimony. He is entitled to a fair fee based on time consumed in rendering his report, on preparation for the trial, and for holding himself in readiness to testify. He may agree to an amount before trial, so long as the fee is not based on the patient's possible recovery or degree of recovery—they would be null and void. The doctor should remain unruffled by hackneyed questions, avoid overstatement when asked regarding the injury and not agree that doctors are subject to error in diagnosis and prognosis. The doctor in testifying must bear in mind, like all citizens, that he must help in administration of justice.

MEDICINE, PRACTICE OF

What Price Chiropody? Rose, G. K. Brit. J. Clin. Pract. 13: 182-85, 1959.

Only members of the Incorporated Society of Chiropodists, founded in Great Britain in 1912, are entitled to be called Registered Medical Auxiliaries. The responsibility of maintaining the high standards of education and ethics is vested in this Society. The five schools in England and three in Scotland provide a 3-year course of education. The entering student must be over 17 years old and have a General Certificate of Education, "with passes in at least four subjects." The course consists of the basic sciences—biology, chemistry, physics—followed by anatomy, physiology, elementary pathology, bacteriology, medicine and surgery as related to diseases of the lower limbs, dermatology, regional surgery, podology, therapeutics, and practical chiropody.

The author, an orthopedic surgeon, while lecturing at one of these colleges, noted that the students had approximately three times as many lectures in orthopedic surgery as he had received as a student in the university, and the course at the university has changed little since then. The student is expected to pass the examinations with a high standing. If 21 or older, he receives the M.Ch.S. degree (Member of the Society of Chiropodists); if under 21 the A.Ch.S. degree (Associate Member). Further courses are required for teaching and for Fellowship in the Society (F.Ch.S.).

The country, therefore, has a body of highly trained men and women with high ethical standards in their work. However, a person can call himself a chiropodist without this education or degree, so long as he does not claim he is a registered medical auxiliary. Only the highly trained and qualified practitioner is required to maintain the highest standards by common law. It is unfortunate that this highly qualified body of professional men does not receive greater recognition. The author criticizes the Society of Chiropodists because it has not achieved close enough liaison with the medical profession, especially in relation to hospital work. In general, the two groups run a rather parallel course, and particularly as relating to orthopedic surgeons.

The members of the Society limit the scope of their activity, and while their education is of high level, much of their education is directed to conditions which ethically they must not treat. This is frustrating to a practitioner of 10-years' experience, who with complete understanding and experience in his permitted work has no possibility of significant advancement in interest and activity.

Tribute is paid to the treatment work done in the world of chiropody, particularly in helping older persons. The summit of its difficulty and of its usefulness is reached in treating the diabetics and patients with vascular insufficiency. Yet if a chiropodist refers his patient for medical and hospital help he knows he will lose his patient. For this reason the younger group may be tempted to continue treating benign conditions, such as bunions and hammer toes, conservatively for a long time, when surgery would be more helpful.

Various appliances and their use are described. Because of their cost, and because the National Health Service provides them, the practitioners will either have to continue application of padding and strapping with its disadvantages and expense of time and money to the patient, or they will need to buy mass-produced appliances which can be satisfactory in only a small percentage of cases. If flatfoot is treated by an efficient heel correcting device, a true cavus foot can develop, which will be disastrous for the child. Treatment of adult forefoot defects are particular problems. The isolated chiropodist in competition with self-prescribed mass-produced corrective appliances "well may

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feel that his long training has been wasted, and his ethical aspirations merely a pious hope in a wicked world."

What must be done to right this situation is up to the Society of Chiropodists itself. The membership consists of highly trained practitioners, and under the present conditions of chiropodial and hospital organizations, they have imposed ethical limitations on their work. This can produce a strong sense of frustration among its members. For the Society to flourish its members must achieve a close liaison with the hospitals, chiefly the orthopedic departments. In most hospitals this would be part-time work, but the chiporodists could have the stimulation of discussions, cooperate in appliance work, and have the opportunity to follow patients through the full range of therapies available for certain conditions. This would necessitate giving up earlier cases requiring treatment of underlying causes of skin disease, but in turn chiropodists would treat patients requiring adequate chiropodial therapy. The isolation of the chiropodist would be relieved, and "his training blossom under the stimulation and encouragement of the wide field of medicine, instead of withering as it must so often do now for want of nourishment and light."

MUSCULOSKELETAL DISORDERS

The Limping Child, Michele, A. A. New York St. J. Med. 60: 205-32, 1960.

An extensive discussion is presented of the many variations of limp—the clinical picture, radiologic findings, laboratory tests, and the prognosis following either conservative or surgical management. Because of the prospect of secondary changes, local or remote, and increasing disability, treatment is of little avail in the late stages. The importance of reinforced iliopsoatic tension signs is emphasized in diagnosis and in choice of treatment.

Variations of the limp are classified. The first is *inequality of the legs* without restriction of motion of the component articulations. This can arise from partial or complete absence of one or more bones; epiphyseal dysgenesis; shortening subsequent to premature epiphyseal closure produced by surgery, trauma or disease; to fracture resulting in nonunion or malunion. The degree of limp depends upon the amount of shortening or lengthening of the limb. The fatigue and exhaustion in walking are alleviated by platform elevation of the shoe for the shorter leg. If disparity in leg lengths is severe, overexertion of the leg muscles may induce scoliosis; equalization of the legs will require operative measures. *Psoatic limp*, secondary to trauma or infectious lesions of the hip, is the result of the body's attempt during walking to ease tension and decrease irritation on the inflamed synovial membrane and capsule which is inducing tension on the iliopsoas. With the hip in slightly flexed and adducted attitude, the knee in compensatory flexion, and the ankle joint in plantar talipes equinus, the child pivots on the ball of the foot, has a weak take-off, the leg swings forward and the pelvis makes a wide circle around the hip to bring about the upward-rotated member into the progression plane. Infectious lesions of the hip may produce this limp. Other conditions are arthrokatadysis, wherein the child has difficulty in walking up and down stairs and also in sitting; dislocation of the hip, which may be congenital, developmental, traumatic, or paralytic or spastic dislocation; transient synovitis of the hip joint; Legg-Perthes disease.

Gonalgic limp secondary to contracture or ankylosis of traumatic or infectious lesions of the knee occurs in discoid cartilage of the knee, osteochondritis dissecans, Osgood-Schlatter disease, rheumatoid arthritis, osteoid osteoma, hemophilia, osteomyelitis, and rheumatic fever. *Podalgic limp*, secondary to disabilities of the ankle or foot, may be caused by functional disability of the foot resulting from a corn, a callus, strain of the longitudinal or transverse arch, sprain of ankle ligaments,

chronic inflammation of the ankle joint, and to various congenital or developmental deformities of ankle and foot. The child assumes the talipes equinus position in cases of painful heel apophysitis, sensitive corn or callus, or any relaxation of the anterior arch of the foot, causing the child to walk on the outer border of the foot. If limping occurs because the ankle joint is fixed in the talipes equinus position by contracture or by ankylosis, there is loss of deploy during the standing period, since the toes touch the ground first, not the heel—the foot is set for take-off through the great toe.

In selection of treatment of pigeon-toe gait or flatfoot, two conditions should be considered: those in which the abnormal gait is a reflection of tibial torsion, and those due to a disturbed mechanism of the iliopsoas. The deformity caused by internal tibial torsion of the leg will include either pigeon-toed attitude (internal rotation), or a foot remaining static with pronated os calcis foot and prominence of the medial border at the calcaneonavicular joint. The author found that the condition can be almost always corrected if at an early age forceful external torsion of the distal shaft of the femur and of the epiphysis is done under general anesthesia, followed by three-quarter cast immobilization with knee in flexion at 90 degrees (to prevent rotation) and the foot in over-corrected position from five to six weeks. He does not favor use of Denis Browne splints in the initial correction, because the footplate position can cause disturbing rotation and angulation of the epiphyseal areas of bone structure of the legs, remote from the area of the distal tibial epiphysis.

A pathologic condition resulting from the tibia or malfunctioning hip is difficult to treat by shoe corrections only. The reenforced iliopsoatic signs should be determined to learn the cause.

Clubfoot (talipes equinovarus) causing podalgic gait, is effectively corrected by plaster cast; the adduction is corrected first and then the talipes equinus. The correction is maintained by use of Denis Browne abduction splints. When walking the patient wears outflare shoes with inner heel wedges. *Flatfoot* with inability to invert or to supinate the foot requires treatment used in arthritic conditions, together with manipulation, correction, cast mobilization, use of Whitman plates and physiotherapy. Surgery or triple arthrodesis may be required if the calcaneonavicular bar is present. *Painful heels,* occurring oftenest between 5 and 12 years of age, may arise from an overprominent posterosuperior aspect of the os calcis and secondary callus pressure formation. It calls for elimination of the stiff shoe counter; if a soft counter is substituted, its height must be increased to prevent friction. *Tendonitis* of the Achilles tendon therapy consists of plaster cast, doughnut elevation of heel, and hydrocortone local treatment. Tension epiphysiolysis, or *calcaneal apophysitis* syndrome, occurring mostly in boys aged 7 to 14 years, resembles Osgood-Schlatter disease, and causes limp and pain in the posterior heel. Treatment is by use of local heat, a cupped doughnut for the heel about 5/8 inch high, and a longitudinal cookie in each shoe.

Antalgic limp, or weight-bearing intolerance of the spine, causes the child to avoid jarring and concussion of the spinal column; the gait is slow and guarded and steps are short. The flip and buckling signs and other neurologic findings establish the diagnosis. The limp is due to pressure on the nerve root or disturbance of the intervertebral foramen.

The *paralytic limp* results from an inability to control oscillations of the pelvis and to attain pelvic position against gravity. Paralysis following anterior poliomyelitis may cause hip limp or limp of the ankle joint and vary from a lurching Gluteus medius to a talipes equinus gait. Hip limp requires surgery, physiotherapy and use of braces. Calcaneal limp is treated with use

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of the ankle-lock brace. In general, braces must be planned according to the complicated conditions. With muscular dystrophy the gait is lordotic, the lordosis increasing and decreasing with each step; in poliomyelitis lordosis does not occur. In cerebral palsy the gait is spastic, with difficulty in carrying out rapid dorsiflexion and plantar flexion. An upright bar with a stop at the ankle prevents flexion while dorsiflexion is free. The brace is worn day and night in moderate cases; in severe adduction contractures, night-control spring braces may be necessary. If the re-enforced iliopsoatic tension signs are positive, transference of the iliopsoas should be considered.

The various disorders occurring in the spine, hips, and lower extremities which cause the patients to limp are described as to possible origin, diagnosis and treatment. The author emphasizes the part played by anthropologic progression in development of these disorders in man. "The primates, including the Neanderthal man, in fact all races of mankind, in assuming the erect posture, have also assumed a vulnerability to the destructive force of the Iliopsoas, a muscle ill-adapted to that posture. . . . When man developed a lumbar lordosis, through the iliopsoatic influence, he set up an intrinsic destructive external-rotation and upward-thrusting force of the head of the femur." The re-enforced iliopsoatic signs, described by the author, whether positive or negative, not only provide a better understanding of the disorder, but provide a proper prognosis.

A Rational Treatment of Congenital Talipes Equino-varus, Critchley, J. E. Med. J. Australia 1: 871-73, 1959.

Gentle correction of this deformity and maintenance of position by plaster of Paris is the treatment advocated. As no pain or muscle spasm occurs, no anesthetic is required. Correction is by repeated gentle manipulation—stretching of any tight structure in the foot. Forcible manipulation tears soft tissues and even bone, requiring repair with fibrous tissue which will become scar tissue that always contracts, causing a relapse.

Correction of the forefoot deformity is done first, then inversion of the heel is corrected, and only *after* these two deformities are completely corrected, correction of the equinus deformity is begun.

The plaster of Paris is carefully applied, and changed every week by the surgeon. If poorly applied the condition is made worse. A padded plaster is used. It is applied to the foot as a shoe, with the aid of a trained assistant. For accurate fitting, narrow rows of padding and plaster of Paris 1 to 2 inches wide are required. The thin, narrow padding is applied with the surgeon holding the foot with the index finger under the great toe and along the head and neck of the first metatarsal, and the thumb on top of the toe, while the assistant applies the padding and plaster of Paris. Padding starts from the top of the foot. Application must be firm and smooth, without billowing, and the great toe entirely covered. A plaster of Paris bandage is applied to the forefoot, then to the hindfoot, forming the shoe. Then applied to the heel, the plaster of Paris is folded back and forth around the back and under the heel, and carefully moulded into the hollows around the tendon of Achilles. Then the finger and thumb are drawn out from the bandage, the cast flattened over the toes, and the forefoot adduction corrected. After the cast "sets," this plaster shoe is used to evert the heel, and the cast completed to hold the correction.

The navicular is moved from the medial side to the front of the head of the talus and the os calcis turned laterally under the talus, thus bringing the forefoot in line with and in front of the hindfoot. The longitudinal axis of the talus now is in line with the great toe, with the longi-

tudinal axis of the talus and the os calcis making an angle of 35 degrees. After correction of the equinus by application of the shoe to control the foot, the whole foot is dorsiflexed at the ankle, thereby avoiding "boating" deformity.

Correction is complete when the foot can be dorsiflexed in eversion. The foot is kept in a cast for eight weeks. After that a night splint is worn for six months.

NEW GROWTHS

Old and New Concept in Treatment of Warts, G. H. Hassard. Illinois Med. J. 114: 212-218, 1958.

Warts are epidermal reactions to a filterable virus. They can be distinguished from corns and calluses because after the horny top is pared off, the papillomatous nature of the central part is seen. After paring a callus, a flat epidermis remains. At that depth a wart bleeds; a callus does not. There are many types of warts, but most of them appear only on other parts of the body than the foot. Verruca plantaris, pinhead to half-dollar in size, and flat like a callus, occurs on the sole and palm, and may be solitary or multiple, the multiple often being misdiagnosed as tinea or dermatophytosis.

Proper treatment of warts requires a procedure that is simple and painless, provides speedy healing without interfering with the patient's duties, without recurrence or permanent damage, and not costly. Various types of therapy are used: (1) Oral medication, with use of mercury protoidide gr. 1/8, once or twice daily after meals for 2 months. Or Bistrimate®[1] one tablet three times a day for 2 months, or Fowler's solution if the wart is of the plana juvenilis type. (2) Parenteral injections given intramuscularly or intragluteal injections of bismuth salicylate, weekly for up to 15 weeks. Sulfarspenamine 0.2 gm. for two injections has proved effective. (3) Vaccine therapy may be used if other methods fail, using sterilized macerated wart in normal saline, strained through a Berkefeld N filter, injected intracutaneously biweekly. (4) Injecting the lesion with sclerosing agent directly into the wart (sodium morrhuate, quinine urethane equal parts, 50 per cent dextrose and 30 per cent chloride, potassium oleate, or 1.5 per cent bismuth sodium tartrate). (5) Surgical excision tends to bring recurrence and scarring. (6) Electrodessication is painful; it requires procaine infiltration first, after which the wart is fulgurized on the surface with medium voltage; then needles are inserted at several points on the edge of the wart, with low dessication. The top is removed, the base curreted and fulgurized; slow healing is followed by scarring. (7) Cryotheraphy is a method of applying dry ice or CO_2 snow on a stick for 1 to 1½ minutes, or liquid nitrogen as a freezing therapy. It is painful and leaves a scar. (8) Radiotherapy by use of radium implants or x-ray treatments is painless, rarely scarring nor becomes infectious. (9) Chemical caustics are dangerous and produce excessive scarring; they are not recommended except in treatment of venereal warts. Other agents used are Podophyllin resin 7.5 gm.; compd. Tr. Benzolin; sulfurated lime solution; salicylic acid in white petroleum, and others. (Directions are given for each.)

Success has been reported with use of Vioform®[2] in children. The author uses ultrasound to facilitate deeper penetration; good results are obtained also by use of ultrasound alone. Excellent results were obtained in 41 patients with use of Vioform Cream 3 per cent and ultrasound energy in 14 to 30 days, and without recurrence.

®[1] Smith, Caroll Dunham Pharm. Co.
®[2] Ciba

V 50 9 SEP 60 XUM

RHEUMATIC DISEASES

Treatment of Rheumatoid Arthritis with Chloroquine, Fuld, H., and Horwick, J. Brit. J. M. 2: 1199-1201, 1959.

Between May 1955 and August 1958, 39 patients were treated with chloroquine and observed for periods up to 4 years. Almost all had been treated elsewhere with gold injections, steroid hormones, and phenylbutazone, without obtaining lasting relief. Since results from chloroquine therapy cannot be expected for about three weeks, other therapeutic measures were used in the meantime: salicylates in the form of calcium aspirin, complete bed rest or until ESR returned to normal, artificial fever therapy, weekly transfusions of one pint of fresh blood, or injections of hydrocortisone acetate into single joints, and graded physiotherapy after the acute stage.

On admission to the hospital, or at the end of induced fever, an initial dose of 600 mg. was given daily; this was reduced if gastric irritation occurred. All but 5 are still on a maintenance dose of 200 to 300 mg. daily. Two patients received no benefit; 3 had gastric upsets. Complete remission followed in 39 per cent; 80 per cent had full remission or major benefit. Some of the best results were obtained in long standing cases (5 to 8 years). Secondary degenerative joint changes with irregularities of the joint surface and narrowing of joint spaces remained unaffected. Remineralization of osteoporotic bones took place during treatment.

No relapse occurred after the initial response to the drug, nor while taking less than 400 mg. daily. It is too early to know how these patients will fare 5 to 10 years from now.

MISCELLANEOUS

Care of the Feet in the Aged Patients, Alvarez, W. C., Geriatrics 14: 405, 1959.

The author visited a home for the aged and found that an office was provided for a podiatrist. He was the most loved person in the home. The superintendent said the aged, particularly women, have painful feet from wearing shoes that were too short, causing corns and ingrowing nails. Many have fallen arches and other foot problems that can be solved by a podiatrist or orthopedist. If a diabetic person in paring a corn cuts the skin, he may develop gangrene and perhaps lose that leg. For that reason diabetics should always use wooden instruments, not metal ones.

In the Cincinnati General Hospital 14 podiatrists care for the feet of the patients with diabetes or with disease of the arteries in the legs. Whereas the amputation rate formerly was between 22 and 24 a month, now 12 years later, there are only 2 to 4 a month. Other hospitals with chiropodists on the staff report that the amputation rate has dropped as much as 68 per cent.

Efforts must be made to avoid traumatizing by mechanical, chemical and thermal agents. The shoes and slippers of the aged should be of soft leather. Circular garters should not be worn. Strong antiseptics, such as tincture of iodine, should not be used on the feet; alcohol and witch hazel can be used. Rubbing lanolin into the skin reduces itching and, therefore, scratching and fewer breaks in the skin. The feet should be washed daily in warm water. Feet can be kept warm in bed by wearing heavy bed socks; heating pads and hot-water bottles must not be used.

"Judge not thy neighbor till thou comest into his place."

—Rabbi Hillel

ORGANIZATION NEWS

Secretaries of local, state, regional, affiliated, subsidiary and other related organizations are invited to submit copy for these columns.

ARKANSAS

The Annual Meeting of the Arkansas State Chiropody Association was held at the Hotel Marion in Little Rock, July 17, 1960. The principal business of the meeting was the change in designation to Arkansas Podiatry Association. Officers elected for the coming year were: President, George F. Heroman, Jr., Pine Bluff; Vice President, L. Blair Shaw, West Memphis; Secretary-Treasurer, Walter C. Gigerich, Hot Springs; E. N. Barron, Little Rock, was elected as Delegate and Bernard Paul, Fort Smith, Alternate, to the National Meeting. William P. Walker of El Dorado was recommended for reappointment to the State Board.

ILLINOIS

The Illinois Podiatry Society has appointed Douglas Durkin of Chicago to the position of executive director, it has been announced by Fred G. Broun, D.S.C., Society President.

Mr. Durkin replaces Miss Ann Fox as administrator of the Society's central office. He will be responsible for public relations programs, inter-professional liaison, and related services.

Durkin is president of Douglas Durkin Associates, Inc., a public relations counseling firm, and also heads up Association Management, Inc., which specializes in development programs for professional and trade associations and societies.

LOUISIANA

At the summer meeting of the Louisiana State Chiropodists' Association, held at Shreveport, Dr. Nicholas Zichichi of New Orleans was presented with a plaque honoring him for 25 years of service to the profession. Dr. Zichichi, a graduate of the Illinois College of Chiropody, class of 1934,

---

"LIFE'S FOUNDATION — YOUR BABY'S FEET" is an outstanding and comprehensive booklet on the growth and care of children's feet. Written for the layman, it is concise, cleverly illustrated and will prove valuable especially to the parents of young children. Many Podiatrists-Chiropodists have received a copy of this booklet and have ordered them in quantity. For those of you who have not ordered and for those who wish to reorder, please clip the order blank below and mail with your check for your supply.

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(National Association of Chiropodists)
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Check payable to Women's Auxiliary, APA, in the amount of $_____is enclosed.

NAME _____

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CITY and STATE _____

SEE THE EXHIBIT AT YOUR REGION CONVENTION

has served as Secretary, Treasurer, Vice President, President of the Louisiana Association, and as Delegate and Alternate to the National Association of Chiropodists. For a number of years he has represented the Louisiana chiropodists as a member of the Louisiana State Board of Medical Examiners.

Speakers at the Louisiana meeting included Earl L. Weibel, D.S.C., Oklahoma City, "Health Insurance versus Socialized Medicine"; William H. Bowdler, D.S.C., Forth Worth, Texas, "Modern Chiropody Practice"; Edward G. Fisch, D.S.C., Austin, Texas, "The Orthopedic Examination"; and M. A. Kutschbach, M.D., Shreveport, "Local Anesthesia Problems."

MASSACHUSETTS

Dr. Henry B. Northrop of Beverly, Massachusetts, celebrated his 100th birthday June 30, 1960. Dr. Northrop, born in Fairfax, Vermont, joined the Association in 1922 and became a Life Member in 1956.

NEW YORK

A basic indoctrination in foot health and podiatry was given to New York State residents and visitors at the recent Health Fair conducted by the Board of Health at the Coliseum in New York. Teams of New York practitioners assisted by students of the M. J. Lewi College of Podiatry examined thousands of children during the 8-day exposition.

A podiatry office setup complete with X-ray equipment was utilized by the practitioners under the direction of Dr. Martin Hazan, President of the New York County Division and Director of the Podiatry Exhibit at the Health Show.

As part of the follow-up to this meeting literature on various aspects of foot health and lists of practitioners have been sent to all registrants at the podiatry booth.

The New York Society will also man a foot health booth at the New York State AFL-CIO convention in order to keep sev-

REGION TEN

ALA., GA., KY., MISS., TENN.

CHIROPODY-PODIATRY SYMPOSIUM

DINKLER PLAZA HOTEL

OCT. 7, 8, 9, 1960

ATLANTA, GEORGIA

***FEATURING:* DR. EARL KAPLAN, DR. RALPH OWENS, DR. IRVING YALE**

INFORMATION

DR. PAUL LEFKOFF, 849 PEACHTREE, ATLANTA, GA.

eral million members of organized labor abreast of the changes which have taken place in modern concepts of podiatry.

OKLAHOMA

Dr. Warren D. Long, Chiropodist for the Oklahoma Christian Home for elderly citizens since 1957 when the home was opened (this is one of 18 such homes in the United States supported by the Christian Church), spends one day a week caring for the feet of the residents.

At present there is room for 60 people in the home. The next project is the construction of a health center to accommodate 40 bed patients. General chiropody and foot hygiene consume 20 hours a month, caring for 5 to 8 patients a visit, 90 per cent of whom are women. Because of their age, sustaining care is a general practice in the management of their foot conditions.

Reverend Whitwell, Director, states there is definite need for podiatric care and also another such home in Oklahoma.

VIRGINIA

Dr. Albert Pincus of Richmond, has been appointed Assistant Clinical Professor of Podiatry at the Medical College of Virginia.

Drs. Milton Cummins and Theodore Levy of Richmond were appointed Clinical Instructors of Podiatry at the Medical College of Virginia. Dr. Cummins was also appointed to the State Board of Medical Examiners by Governor Almond of Virginia. His term will run for 5 years.

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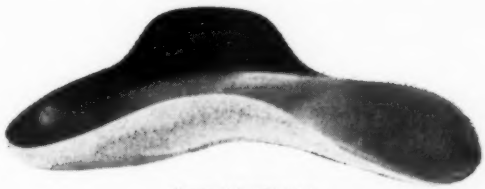

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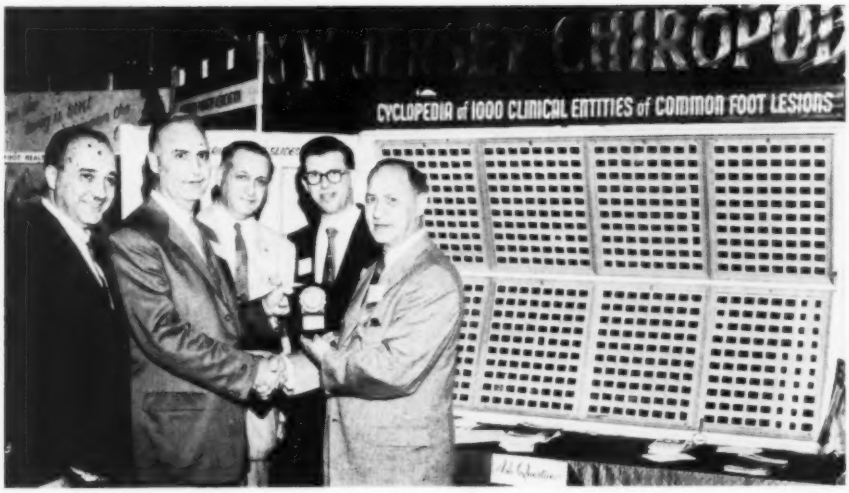

Award for Educational Exhibit

At the Essex County Health Fair, the New Jersey Chiropodists Society was awarded third place for the most educational exhibit at the fair. In the illustration, from left to right, are P. Cuozzo, D.D.S., President of the Essex County Interprofessional Health Council; Saul Israel, D.S.C., Chairman of the Exhibits, accepting plaque from S. William Kalb, M.D., General Chairman of the Health Fair. Also present were Harry Silver, D.S.C. and Harold Estersohn, Chairman of the Eastern Division, New Jersey Chiropodists Society.

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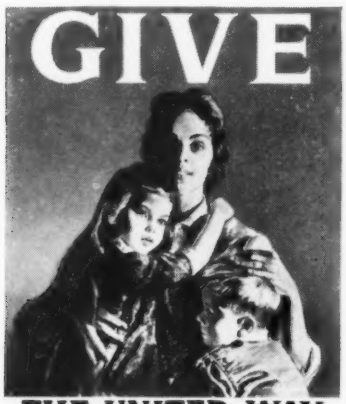
originator of foot balance inlays is directed in all its endeavors to accomplish this result

AMERICAN COLLEGE OF FOOT SURGEONS

The 1961 convention of the American College of Foot Surgeons will be held January 22-26, 1961, at the Eden Roc Hotel, Miami Beach, Florida. Arrangements can be made for an extension trip to Nassau, Bahamas.



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☐ Please send me more information. I understand there is no obligation and no salesman will call.

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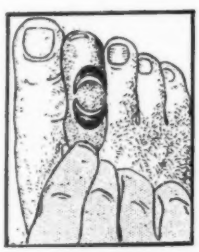

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FLORIDA—Errata

On page 677, August 1960 issue of the *Journal*, Leo Wachtel, M.D., was erroneously listed as President of the Florida Podiatry Association. This should read, "Leo Wachtel, M.D., President of the Florida Medical Association."

DEATHS REPORTED

Jessie C. Brown
New Orleans, La.

Edgar E. Helbing
Denver, Colo.

Dr. Helbing passed away July 10, 1960. He was a graduate of the former Colorado College of Podiatry, class of '37, and was an active member in the state and national associations.

D. F. Dull
Youngstown, Ohio

Milton Grossman
New York, N. Y.

Margaret E. Tortora
Greenwich, Conn.

Dr. Tortora passed away August 1, 1960. She was a graduate of the First Institute of Podiatry, class of '31, and was an active member of the state and national associations.

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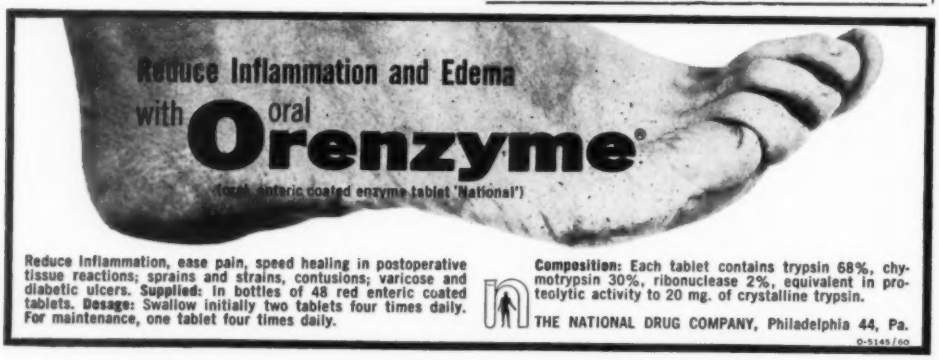

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MILLER SHOE COMPANY MAKES THIRD ANNUAL AWARD TO COLLEGES

The Board of Directors of the Miller Shoe Company, Cincinnati, Ohio, has announced that it has awarded its third annual grant of $1,000 to each of the following colleges of chiropody-podiatry: California College of Chiropody, Chicago College of Chiropody, Illinois College of Chiropody and Foot Surgery, M. J. Lewi College of Podiatry and Ohio College of Chiropody.

WOMEN'S AUXILIARY MESSAGE

Occasionally a podiatrist will ask, "Why the fuss about increasing the membership of the Women's Auxiliary?" There are many answers to the question, but here are a few pertinent ones:

In numbers there is strength and what 700 Auxiliary members in the United States are doing, 1,000 could do better.

Because we have something to share or something to sell, if you please—Our Profession—which brings values far in excess of the cost in time and money.

Because a living thing such as the Women's Auxiliary is like a plant in the field. It remains living as long as it grows. When it stops growing, it goes to seed, and when it goes to seed it dies!

If your wife is not a member of the Auxiliary, enlist her now for us.

MRS. CLEOTHA PARHAM
President

troubled toes! . . . give them a chance to breathe . . .

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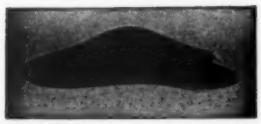

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CONVENTION DATES AND MEETING NOTICES

American Podiatry Association
Miami Beach, Fla., Aug. 24-29, 1961
Americana Hotel
Seward P. Nyman, Convention Manager
3301 16th St., N.W., Washington 10, D. C.
Michael I. O'Connor, Exhibit Manager
428 E. Preston St., Baltimore 2, Md.

Region One
(Conn., Maine, Mass., N. H., R. I., Vt.)
Hartford, Conn., Oct. 21-23, 1960
Statler Hilton Hotel
Dr. Edward H. Buchbinder
10 Allyn St., Hartford, Conn.

Region Two
(New York)
Mr. Gilbert Hollander, Ex. Sec.
353 W. 57th St., New York, N. Y.

Region Three
(Del., Md., N. J., Pa.)
Dr. B. C. Egerter, Gen. Chairman
507 Liberty Ave., Pittsburgh, Pa.

Region Four
(Ohio)
J. Edwin Farmer, Ex. Sec.
Fifty W. Broad St., Columbus, Ohio

Region Five
(Ill., Ind., Mich., Wis.)
Dr. Ralph M. Ticko, Pres.
536 W. Wisconsin Ave., Milwaukee, Wis.

Region Six
(Colo. Iowa, Kan., Minn., Mo., Nebr., N. Dak., S. Dak.)
Des Moines, Iowa, Apr. 7-9, 1961.
Savery Hotel
Drs. Stewart E. Reed and Ralph C. Kirkwood,
425 Kresge Bldg., Des Moines, Iowa

Region Seven
(Idaho, Mont., Ore., Wash., Wyo.)
Gordon R. Tobin, Convention Chairman
153 Third Ave., North, Twin Falls, Idaho

Region Eight
(D. C., N. C., S. C., Va., W. Va.)
Washington, D. C., Nov. 11-13, 1960
Shoreham Hotel
Charles Turchin, Chairman
818-18th St., N.W., Washington, D. C.

Region Nine
(Florida)
Clyde R. Huston, Ex. Sec.
5625 Commerce St., Jacksonville, Fla.

Region Ten
(Ala., Ga., Ky., Miss., Tenn.)
Atlanta, Ga., Oct. 7-9, 1960
Dinkler Plaza Hotel
Dr. Paul Lefkoff, Secretary
202 Burdine Bldg., 849 Peachtree St., N.E.,
Atlanta, Ga.

Region Eleven
(Ark., La., N. Mex., Okla., Texas)
S. D. Tomlinson, Gen. Chairman
3101 Classen Blvd., Oklahoma City, Okla.

Region Twelve
(Ariz., Cal., Nev., Utah)
Dr. Alfred G. Roos
209 Post St., #412, San Francisco 8, Calif.

American Academy of Chiropodists
Canadian Podiatry Association
Joint Meeting
Toronto, Ontario, Canada, Oct. 23-24, 1960
Royal York Hotel
Dr. Charles E. Kelley
2488 Lee Rd., Cleveland Heights, Ohio
Dr. L. Hurwitz
3017 Bathurst St., Toronto, Ont., Can.

Attend Your

STATE & REGIONAL MEETINGS

THEN YOUR NATIONAL

MOOD ELEVATORS

Contributions to this column are more than welcome. In fact it depends upon them.
A.O.P.

Mrs. B. had been put on a rigid reducing diet. A neighbor dropped in one day and found her eating a huge slice of apple pie. "I thought you were on a diet?" she exclaimed.

"I am," said Mrs. B., "but I've had my diet; now I am eating my dinner."

What's new?

"The earth is degenerating. Bribery and corruption abound. Children no longer mind their parents. Every man wants to write a book and it is evident that the end of the world is fast approaching."

From an Assyrian Tablet, 2800 B. C.

Before marriage a girl embraces her man. After she gets him she puts the squeeze on him.

YOUR APPOINTMENT CARD SAYS 2 P.M.
MY APPOINTMENT BOOK SAYS 2 P.M.
MY SECRETARY SAYS 2 P.M. AND
THE CLOCK SAYS 3 P.M. YES,
MRS. TARNDI YOU ARE A BIT LATE

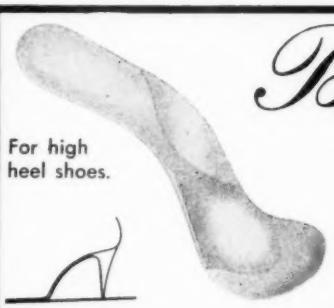
"OR ELSE!"

A drunk staggered down the street and landed up against a telephone pole. He felt his way around and around the pole, then stepped back and moaned, "I'm trapped! There's no way out of this place!"

Jim and Pete were getting ready to go home from the office. Jim said, "These shoes are too dern tight. I can hardly walk."

"Well, why don't you take 'em off?" asked Pete.

"Listen," replied Jim. "It ain't bad enough I gotta eat my wife's bum cooking. It ain't bad enough I gotta look at my mother-in-law and listen to her talk. My daughter married a guy I got no use for and they got four kids as mean as all git-out. The only pleasure I have when I get home is taking off these shoes."



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Vosburg Foot Appliance Co.	765
Westwood Pharmaceuticals	702
Winthrop Laboratories	713
W. Wooley & Co.	774
Wynlit Pharmaceuticals	3rd Cover

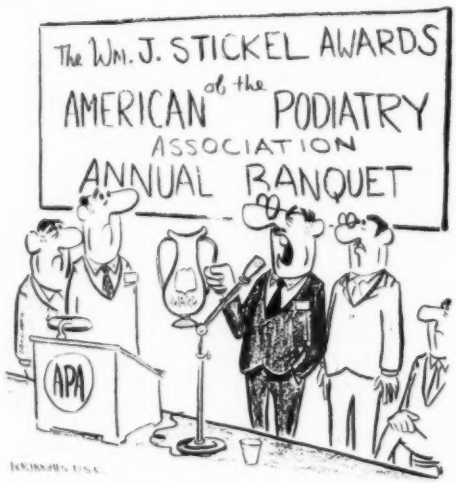
TAKE FIVE

Old Doc Friendly down the street says that even though we have proven quite conclusively that man's foot has grown appreciably in the last century, he can still manage to get it into his mouth.

I never worry about the old 48 when the Democrats and Republicans start in electioneering. They are a sturdy group of states and are used to it. I only hope that Alaska and Hawaii are strong enough to survive.

Mary Friendly says that the Air Force has nothing on their family car, it is debt propelled.

DR. POD By Bob Hughes, D.S.C.



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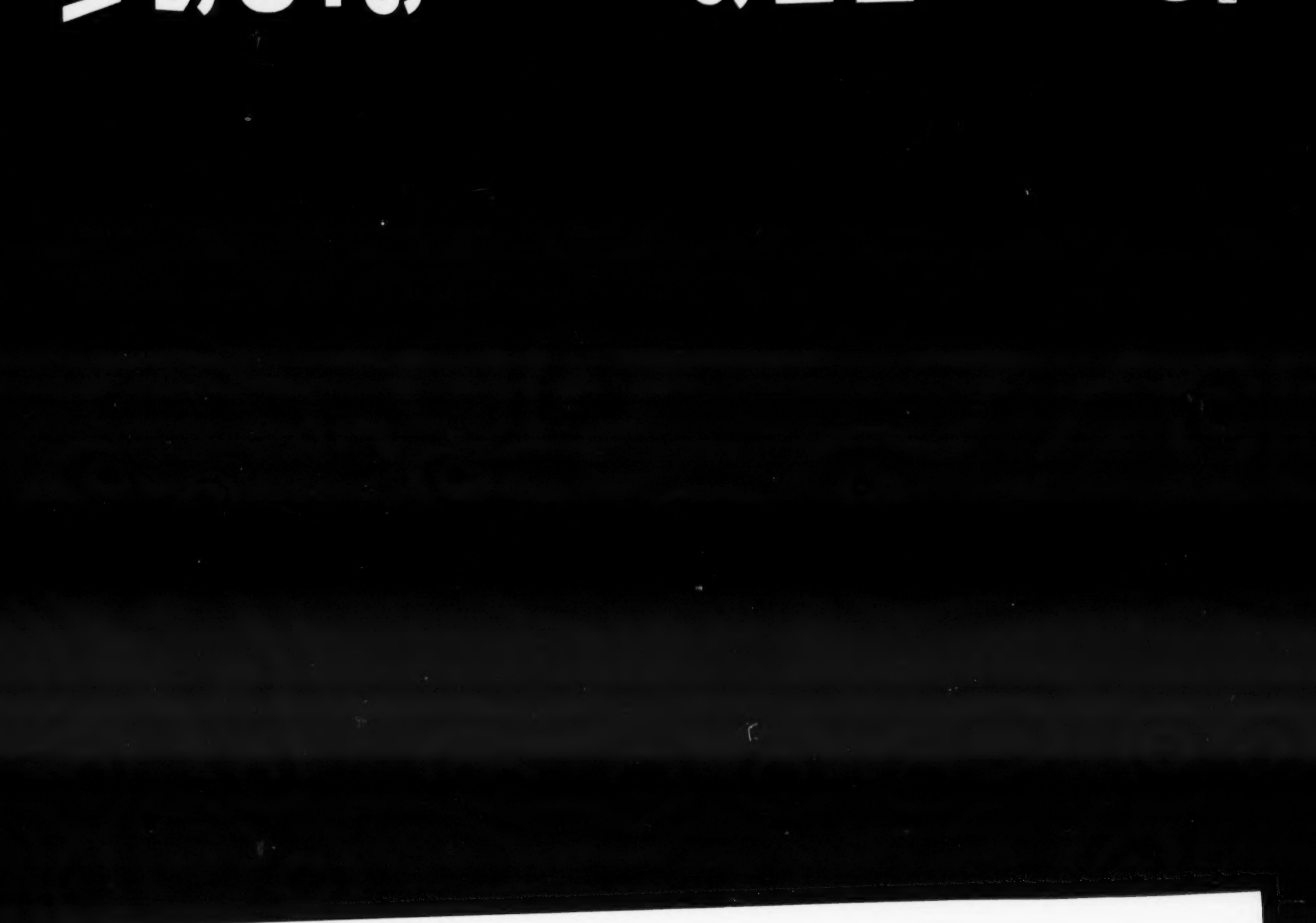
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